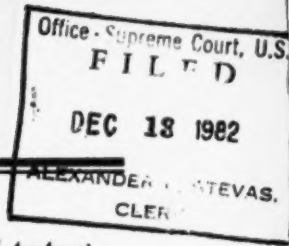


No. _____



IN THE
Supreme Court of the United States

OCTOBER TERM, 1982

NATIONAL ASSOCIATION OF HOME
HEALTH AGENCIES, *et al.*,

Petitioners,

v.

RICHARD S. SCHWEIKER, SECRETARY OF
HEALTH AND HUMAN SERVICES,

Respondent.

**PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

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QUESTIONS PRESENTED FOR REVIEW

Whether the Secretary of the Department of Health and Human Services was authorized to issue an administrative instruction terminating the long-standing right of home health agencies to elect to receive Medicare payments directly from the federal government.

Whether the Court of Appeals for the District of Columbia Circuit exceeded the proper scope of its review by sustaining the authority for the agency's action on grounds which were not set forth in the administrative instruction.

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1982

No. _____

NATIONAL ASSOCIATION OF HOME
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Petitioners,

v.

RICHARD S. SCHWEIKER, SECRETARY OF
HEALTH AND HUMAN SERVICES,

Respondent.

**PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

Petitioners, National Association of Home Health Agencies, *et al.*¹ respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the District of Columbia Circuit entered in this proceeding on September 14, 1982 reversing in part the opinion of the United States District Court for the District of Columbia.

OPINIONS BELOW

The Circuit Court's decision is published in CCH Medicare and Medicaid Guide [New Matters] ¶ 32,201 (D.C.

¹ A list of the parties which appeared below and their member organizations and parent companies is provided in Appendix H.

Cir. 1982). Appendix A. The opinion of the District Court, which the District of Columbia Circuit partially reversed, is published in CCH Medicare and Medicaid Guide [1982 Transfer Binder] ¶ 31,873 (D.D.C. 1982). Appendix C.

JURISDICTION

The judgment of the District of Columbia Circuit Court of Appeals was entered on September 14, 1982. A timely motion for a stay of mandate was filed on September 29, 1982 and was granted for a period of 30 days on October 27, 1982. A timely motion for an extension of the stay of mandate until the filing of this petition was filed on November 24, 1982. This petition was filed within ninety days of the date of the entry of the judgment of the District of Columbia Circuit Court of Appeals. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATORY PROVISIONS INVOLVED

The following statutes and substantive rules are relevant to this matter and are set forth in pertinent part in Appendices E, F, and G:

- 42 U.S.C. § 1395g(a);
- 42 U.S.C. § 1395h(a);
- 42 U.S.C. § 1395kk(a);
- 42 C.F.R. § 421.103(a) and (b);
- 42 C.F.R. § 421.104(b)(1) and (2);
- Part A Intermediary Letter A-81-32

STATEMENT OF THE CASE

This action was instituted by two national associations of home health agencies, a corporation which owns and operates 48 home health agencies, and 37 individual home health agencies to enjoin an administrative instruction

issued by the Secretary of the Department of Health and Human Services ("Secretary") on December 8, 1981. By means of that administrative instruction, the Secretary sought to abolish the right of freestanding home health agencies to have Medicare reimbursement determinations and payment made directly by the Secretary's Office of Direct Reimbursement ("ODR") and to compel all freestanding home health agencies to use non-governmental intermediaries. Appendix G. The Secretary's instruction represented a reversal of a policy which had been in effect continuously during the 15-year history of the Medicare program under which home health agencies were accorded the right, which they were encouraged to exercise, to elect to deal directly with the Secretary rather than through an intermediary.

The petitioners and their members had exercised that right and spent millions of dollars developing electronic data processing and billing procedures which conformed to those used by ODR. The Secretary's December 8, 1981 instruction sought to sever those relationships and to compel all freestanding home health agencies to begin using non-governmental intermediaries designated on a statewide basis.

On December 24, 1981, petitioners filed suit to temporarily restrain and preliminarily enjoin the Secretary's action which was to be implemented over the course of calendar year 1982 based on the beginning of the freestanding home health agencies' fiscal years. Petitioners' motion for a temporary restraining order was denied on December 29, 1981 and the case was set for an expedited hearing. Subsequently, however, the Secretary sought to accelerate implementation of his action before the District Court could act, and petitioners were granted

a temporary restraining order on March 1, 1982. Appendix D, 66a.

On March 10, 1982, the District Court issued its decision finding that it had jurisdiction under 28 U.S.C. § 1331 (federal question jurisdiction), that the Secretary's administrative instruction violated petitioners' right to elect direct payment under 42 U.S.C. § 1395g(a) and 42 C.F.R. §§ 421.103 and 421.104, that the instruction was not authorized under any of the statutory bases cited by the Secretary, and that the instruction was issued in violation of the rulemaking requirements of the Administrative Procedure Act (5 U.S.C. § 553).

On September 14, 1982, the Court of Appeals affirmed the District Court's decision with respect to jurisdiction and the rulemaking requirements of the Administrative Procedure Act, but reversed the District Court's decision with respect to petitioners' right to direct payment. Petitioners seek review of only that portion of the District Court decision which was reversed.

REASONS FOR GRANTING THE WRIT

- 1. The Issue In This Case Is Of Extreme Importance To All Health Care Providers Which Participate In The Medicare Program.**

The Secretary's December 1980 instruction would have forced 469 freestanding home health agencies to sever their relationships with ODR and begin receiving Medicare reimbursement determinations and payments through an intermediary. Petitioners presented uncontradicted evidence that the Secretary's policy, if implemented, would cost the directly affected home health agencies \$10 million to \$30 million and would result in the disruption and less efficient administration of Medicare home health benefits.

In addition, petitioners presented undisputed evidence that the Secretary's policy would cost the Medicare program millions of dollars in order to equip, train and reimburse the intermediaries to perform the very same services which had been performed by ODR in a highly efficient manner.

Finally, it was undisputed that much of the additional cost to the home health agencies would not be compensated by Medicare, and that even those costs which Medicare would recognize would ultimately be borne by the Medicare beneficiaries and other contributors to the Medicare trust fund. By contrast, the Secretary never produced a single study or analysis comparing the cost and efficiency of abolishing the right to direct payment with the cost and efficiency of retaining that option.

Beyond the 469 freestanding home health agencies which would have been directly affected, the Secretary's policy would have abolished the right to elect direct payment for 2475² freestanding home health agencies which were then using an intermediary. Such an option is extremely important for home health agencies using intermediaries because there are no formal appeal rights for a home health agency, or any other type of participating Medicare provider, to obtain relief from an intermediary which fails to efficiently administer Medicare payments.

The Court of Appeals decision, however, contains additional adverse consequences for providers of health care under the Medicare program which were not contained in the Secretary's December 1981 instruction. The sole

² See Plaintiffs Exhibit 37 in the District Court Record.

statutory basis cited in the Secretary's December 1981 instruction was the Omnibus Budget Reconciliation Act of 1980 which directed the Secretary to designate regional intermediaries for freestanding home health agencies.³ Appendix G, 73a. Both the Court of Appeals and the District Court held that the 1980 amendment merely directed the Secretary to abolish the choice of intermediaries for those freestanding home health agencies which wished to use an intermediary but that the 1980 amendment did not compel or authorize the Secretary to force all home health agencies to use an intermediary rather than ODR.

The Court of Appeals upheld the Secretary's authority to abolish the right to direct payment and relied upon 42 U.S.C. § 1395kk which was not cited in the Secretary's instruction. In reaching its decision, the Court determined that § 1395kk "would authorize the Secretary to perform *any* of his Medicare functions, including his reimbursement functions, either directly or indirectly . . ." (emphasis in original). Appendix A at 20a. Thus, the Court of Appeals holding jeopardizes not only the rights of 2944⁴ freestanding home health agencies but also the rights of 12,800⁵ other Medicare health care providers, including 1295⁶ providers which currently receive direct payment through ODR.

It is clear that the Secretary would not hesitate to exercise his authority broadly if he were not currently

³ Pub. L. No. 96-499, § 930(o), 94 Stat. 2599, 2632 (1980) (codified at 42 U.S.C. § 1395h(e)(4) (Supp. 1980)).

⁴ See, Plaintiff's Exhibit 37 in the District Court Record.

⁵ See, 47 Fed. Reg. 7269 (Feb. 18, 1982).

⁶ *Id.*

enjoined because a proposed regulation has already been published which would alter existing regulations to permit the Secretary to abolish direct payment for all providers of health care services under the Medicare program. 47 Fed. Reg. 7269 (Feb. 18, 1982). Accordingly, petitioners contend that the issue presented is worthy of Supreme Court review because it is of great importance to 12,800 providers of health care which participate in the Medicare program.⁷

2. The Court Of Appeals Decision Raises An Issue Of Fundamental Importance To The Future Administration Of The Medicare Program.

By holding that the Secretary is authorized to perform "any" of his Medicare functions either directly or indirectly by contract, the Court of Appeals recognized a limitless grant of authority which could well cause a drastic change in the way the Medicare program is administered.

The Secretary is charged with performing numerous functions under the Medicare Act including issuing necessary regulations (42 U.S.C. § 1395hh), finally adjudicating reimbursement disputes (42 U.S.C. § 1395oo(f)(1)) and, of course, generally administering the Medicare Act

⁷ Resolution of the issue in this case will also avoid further litigation such as that represented by *Carl H. Newman, d/b/a Lydia E. Hall Hospital v. Schweiker*, Civil Action No. 82-0794 (D.D.C.) which seeks to enjoin the Secretary from abolishing the right to direct payment for a hospital. That litigation has been stayed pending the final outcome in this case.

itself (42 U.S.C. § 1395kk(a)).⁸ Congress could not realistically have intended that the Secretary could contract out "any" of the functions he is charged with performing under the Medicare Act. Yet, the unqualified language of the Court of Appeals decision inevitably leads to that conclusion.

Furthermore, the Court of Appeals decision interpreting § 1395kk is in direct conflict with the holding in *St. Louis University v. Blue Cross*, 537 F.2d 282, 293 (8th Cir. 1976) *cert. denied*, 429 U.S. 977 (1976). In that case, the Court of Appeals for the Eighth Circuit held that the Secretary must retain sufficient power to review intermediary determinations in reimbursement disputes to assure compliance with Medicare statutes and regulations. Under the rationale of the Court of Appeals decision in this case, the Secretary would be permitted to contract out the very functions he was forbidden to delegate in *St. Louis University v. Blue Cross*, *supra*.

⁸ Examples of some of the other functions the Secretary is charged with performing under the Medicare Act are, determining annual the amount of the inpatient hospital deductible which Medicare patients must pay (42 U.S.C. § 1395e(b)(2)); certification of wages to be used as a basis for the tax to fund the Part A Medicare trust fund (42 U.S.C. § 1395i(a)); serving on the Board of Trustees for the Part A trust fund along with the Secretaries of Labor and the Treasury (42 U.S.C. § 1395i(b)); certification of funds from the Part A trust fund for Medicare beneficiary payments and administrative expenses (42 U.S.C. § 1395i(h)); determining the amount of premiums which Medicare beneficiaries must pay for Part B coverage (42 U.S.C. § 1395r); serving on the Board of Trustees for the Part B trust fund along with the Secretaries of Labor and the Treasury (42 U.S.C. § 1395t(b)); deciding whether to waive fire and safety requirements in a hospital (42 U.S.C. § 1395x(e)); and appointing the Provider Reimbursement Review Board which reviews Medicare reimbursement disputes (42 U.S.C. § 1395oo(a)).

3. The Court Of Appeals Decision Is In Conflict With The Well Established Construction Of The Medicare Act By The Secretary And By Congress.

It is undisputed that the Secretary has interpreted the Medicare Act over its 15-year history as providing a right to providers to elect to be reimbursed directly by the government or through an intermediary. Appendix A, 3a. On February 23, 1966, less than seven months after the enactment of the original Medicare legislation, the Secretary's own Office of the General Counsel issued a legal opinion analyzing the same statutory provisions which are at issue in this case. That contemporaneous legal opinion concluded that Medicare providers have the option under 42 U.S.C. § 1395g(a) to receive direct payment and that none of the language contained in 42 U.S.C. § 1395kk eroded that "clear prerogative."⁹

Existing Medicare regulations unequivocally state that providers may receive Medicare payments through an intermediary or "exercise their *right* to receive payment directly . . ." (emphasis added) from the Secretary. 42 C.F.R. § 421.103(a) and (b); 42 C.F.R. § 421.104(b)(2). Those regulations embodying the agency's contemporaneous interpretation of the statute were originally promulgated in 1968 and were repromulgated on June 23, 1980 and again on October 1, 1980. Appendix F, 70a-71a.¹⁰

⁹ Court of Appeals, Joint Appendix, 180-181.

¹⁰ The regulations were originally promulgated at 20 C.F.R. §§ 405.651(a) and 405.654 (33 Fed. Reg. 11277-78 (August 8, 1968)) as set forth in Appendix D. The regulations were subsequently repromulgated in their current form at 45 Fed. Reg. 42182 (June 23, 1980). They were subsequently recodified into title 42 of the Code of Federal Regulations. 45 Fed. Reg. 64912 (October 1, 1980).

There have been at least seven occasions beginning with the enactment of the original Medicare legislation in 1965 where Congress has clearly indicated that it intended for providers to have the right to deal directly with the Secretary.¹¹ That intent was reaffirmed most recently in the Conference Committee report accompanying the 1980 amendments to 42 U.S.C. § 1395h(e) which stated that

[i]n requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration.

(Emphasis supplied.) H. Conf. Rep. No. 96-1479, 96th Cong., 2d Sess., 129 (1980). Accordingly, there is an unbroken line of expressions of congressional intent stretching from the enactment of the Medicare legislation in 1965 through the enactment of the 1980 amendments which indicates that Congress intended for providers to have the option of direct payment.

In reviewing the District Court's decision, the Court of Appeals rejected the agency's own contemporaneous interpretation of the statute, its subsequent 15-year interpretation of the statute, the agency's own regulatory provisions, as well as the numerous consistent ex-

¹¹ S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. and Admin. News 1993; H.R. Rep. No. 213, 89th Cong., 1st Sess., 45 (1965); S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. and Admin. News, 2104; H.R. Rep. No. 213, 89th Cong., 1st Sess., 147-48 (1965); H.R. Rep. No. 95-393, Part I, 95th Cong., 1st Sess., 68 (1977); H.R. Rep. No. 95-393, Part II, 95th Cong., 1st Sess., 76 (1977); H. Conf. Rep. No. 96-1479, 96th Cong., 2d Sess., 129 (1980).

pressions of congressional intent all of which repeatedly confirm that providers have the option to be reimbursed directly rather than through an intermediary. The Court of Appeals relied instead on two isolated statements from the legislative history to the original Medicare legislation, one of which merely parrots the language of 42 U.S.C. § 1395kk and neither of which addresses the situation where a provider wishes to deal directly with the government.¹²

The analysis by the Court of Appeals represents a radical departure from the type of analysis this Court has adopted in examining the reversal of an agency's interpretation of a statute it has administered for a period of years. Typically, an agency's abrupt reversal of its interpretation of a statute will not be sustained where that interpretation is contrary to the agency's interpretation which is more contemporaneous with the enactment of the statute, the agency's long-standing practice, and consistent expressions of legislative intent indicating that Congress understood and supported the agency's original interpretation. *Watt v. Alaska*, 451 U.S. 259, 101 S.Ct. 1673, 1681 (1981); *Train v. Colorado Public Interest Research Group*, 426 U.S. 1 (1976); *General Electric Company v. Gilbert*, 429 U.S. 125, 142 (1976); *Morton v. Ruiz*, 415 U.S. 199, 228-230 (1974); *United States v. Leslie Salt Company*, 350 U.S. 383, 396 (1956); *Norwegian Nitrogen Products Co. v. United States*, 288 U.S. 294, 308-315 (1933).

In cases where an agency charged with administration of a statute has sought to reverse a long-standing practice which was based upon its own contemporaneous in-

¹² S. Rep. No. 404, 89th Cong., 1st Sess., 53, reprinted in 1965 U.S. Code Cong. and Admin. News 1943, 1944; H.R. Rep. No. 213, 89th Cong., 1st Sess., 1974 (1965).

terpretation, this Court has required a careful examination of the legislative history of the statute to determine whether there exists “. . . the clear indication of legislative intent that we might expect before recognizing such a change in policy . . .” *Train v. Colorado Public Interest Research Group*, *supra*, 24. See also *Watt v. Alaska*, *supra*, 101 S.Ct. at 1681. The legislative history of the statutory provisions which were at issue before the Court of Appeals does not contain any indication that Congress intended to abrogate the long-standing practice of permitting providers to receive Medicare reimbursement determinations and payment directly from the government. To the contrary, every reference to that policy in the legislative history of the Medicare Act from 1965 until as recently as 1980, indicates that Congress intended for the policy to remain unchanged.

The Court of Appeals relied on the principle that powers once granted by Congress are not lost by being allowed to lie dormant. See *United States v. Morton Salt Company*, 338 U.S. 632, 647-48 (1950). That principle loses relevance, however, in a case such as this where the agency charged with administration of the statute interprets the scope of its powers at the time of the statute's enactment, follows that interpretation for 15 years, incorporates it into its regulations, and where Congress repeatedly refers to and endorses that interpretation in subsequent legislative history.

Since the inception of the Medicare program, the Secretary has interpreted 42 U.S.C. §§ 1395g, 1395h and 1395kk as not conferring authority upon the Secretary to compel providers to use intermediaries. Accordingly, this case does not involve a situation where an agency's powers have lain dormant or been ignored. The Secretary's authority with respect to use of intermediaries has been

the subject of extensive administrative and congressional review and has never been found to permit the prohibition of direct payment.

4. The Court Of Appeals Decision Ignores A Fundamental Principle Of Statutory Construction.

It is a fundamental principle of statutory construction that a more specific statute will be given precedence over a more general one. *Busic v. United States*, 446 U.S. 398, 406 (1980). The statutory provision on which petitioners rely, 42 U.S.C. § 1395g, expressly directs the Secretary to make Medicare determinations and payment to providers of services "under this part."¹³ Section 1395g is contained in Part A of the Medicare Act which encompasses specific provisions for Medicare reimbursement for participating providers of services. See 42 U.S.C. §§ 1395c-1395i-2. By contrast, 42 U.S.C. § 1395kk, on which the Court of Appeals relied, confers general contracting authority upon the Secretary for unspecified "functions." Further, that statutory provision is contained in Part C of the Medicare Act which encompasses certain miscellaneous sections applicable to Parts A and B. 42 U.S.C. §§ 1395x-1395ww.

If the Court had applied the foregoing established tool of statutory construction in this case, it would have reached the same conclusion as the agency's Office of the General Counsel in its February 23, 1966 memorandum. That memorandum concluded that while the Secretary may have the power under 42 U.S.C. § 1395kk to contract

¹³ By contrast, 42 U.S.C. § 1395h which governs the Secretary's authority to use intermediaries, states applies only where a provider "wishes" to have Medicare payments made through an intermediary. 42 U.S.C. § 1395h(a).

out certain of his functions, he does not have the power under § 1395kk to force a provider to use an intermediary because his authority to perform that function is specifically controlled by 42 U.S.C. §§ 1395g and 1395h. By totally ignoring the difference in scope between §§ 1395g and 1395h on the one hand and § 1395kk on the other, the Court of Appeals decision is in conflict with Supreme Court precedent and with an established principle of statutory construction.

5. The Court Of Appeals Decision Conflicts With Established Supreme Court Precedent Regarding The Proper Scope Of Judicial Review.

In *Securities and Exchange Commission v. Chenery Corporation*, 332 U.S. 194, 195-196 (1947), this Court found it to be a fundamental rule of administrative law that

. . . a reviewing court, in dealing with a determination . . . which an administrative agency alone is authorized to make, must judge the propriety of such action solely on the grounds invoked by the agency.

That principle has been reaffirmed recently in *Industrial Union Department, AFL-CIO v. American Petroleum Institute*, 448 U.S. 607, 631 (1980).

In this case, the Court of Appeals exceeded the bounds established by this Court in *Chenery*. The only ground for the Secretary's action which was set forth in the December 1981 instruction was "P.L. 96-499," the Omnibus Budget Reconciliation Act of 1980. Appendix G, 73a. The Court of Appeals concluded that the Secretary's action was not authorized or directed by that legislation. Appendix A, 28a.

The Court of Appeals, however, sustained the Secretary's authority to take the action described in the December 1981 instruction based solely upon 42 U.S.C.

§ 1395kk. That statutory provision was not cited in the administrative instruction and was suggested as support for the agency's action for the first time in briefs filed by agency counsel. An established corollary to the *Chenery* rule is that

[t]he courts may not accept appellate counsel's *post hoc* rationalizations for agency action . . ."

Burlington Truck Lines, Inc. v. United States, 371 U.S. 156, 168 (1962). Accordingly, the Court of Appeals' reversal of the District Court decision was in direct conflict with the decisions of this court regarding the scope of judicial review.

CONCLUSION

For these reasons, a writ of certiorari should issue to review the judgment and opinion of the District of Columbia Circuit Court to the extent that it reversed the decision of the District Court for the District of Columbia.

Respectfully submitted,

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RONALD N. SUTTER,
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APPENDIX A
United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 82-1293

NATIONAL ASSOCIATION OF HOME
HEALTH AGENCIES, *et al.*

v.

RICHARD S. SCHWEIKER, *et al.*, *Appellants*

Appeal From The United States District Court
for the District of Columbia
(D.C. Civil Action No. 81-03160)

Argued 27 May 1982
Decided 14 September 1982

Margaret E. Clark, Attorney, Department of Justice with
whom *Stanley S. Harris*, United States Attorney and
Anthony J. Steinmeyer, Attorney, Department of Justice
were on the brief, for appellants.

James C. Pyles for appellees.

Before: WILKEY, *Circuit Judge*, and ROBB and FAIRCHILD,*
Senior Circuit Judges.

Opinion for the Court filed by *Circuit Judge WILKEY*.

*Senior Judge, U.S. Court of Appeals for the Seventh Circuit,
sitting by designation pursuant to 28 U.S.C. § 294(d) (Supp. IV
1980).

WILKEY, Circuit Judge: Appellants, the Secretary of Health and Human Services and the Administrator of the Health Care Financing Administration (hereinafter referred to collectively as the Secretary), appeal from a district court decision invalidating a regulation requiring Home Health Agencies to seek Medicare reimbursement determinations and payments from government-designated regional intermediaries. The Secretary maintains that the district court did not have jurisdiction to decide the issues involved. He also challenges the lower court's holdings that the Secretary lacked the statutory authority to promulgate the regulation and that he failed to comply with the notice and comment requirements of the Administrative Procedure Act (APA).¹

We hold that the district court properly exercised its jurisdiction and that it correctly concluded that the Secretary was required to comply with the APA's notice and comment provisions. However, we reverse its holding that the Secretary lacked the authority to promulgate the regulation in question.

I. BACKGROUND

A. *Statutory Scheme*

The Medicare Act,² enacted in 1965, created two distinct, but interrelated, types of health insurance coverage for the aged and disabled. Part B of the Act covers the cost of physician and non-hospital services.³ Part A provides coverage for inpatient hospital services, post-hospital extended care services and home health services.⁴ Home health agencies (HHAs) provide Part A services to a patient in his home, as a lower cost

¹ 5 U.S.C. § 553 (1976).

² 42 U.S.C. §§ 1395-1395tt (1976 & Supp. IV 1980).

³ *Id.* §§ 1395j-1395w (1976 & Supp. IV 1980).

⁴ *Id.* §§ 1395c-1395i (1976 & Supp. 1980).

alternative to institutional care.⁵ The present litigation involves the mechanism for making reimbursement determinations and payments to HHAs under Part A of the Act.

Under the Act qualified providers of Part A health services are entitled to be reimbursed for the reasonable cost of providing services to Medicare beneficiaries.⁶ At the inception of the Medicare program in 1965, HHAs, like other qualified providers, had the option of nominating an intermediary to determine the proper amount of reimbursement and make those payments.⁷ When an HHA chose to use an intermediary, the Secretary would enter into a cost-reimbursement contract with the nominated intermediary.⁸ Alternatively, if the HHA chose not to use an intermediary, it submitted its claims directly to the Secretary.⁹ Under the Act, the Secretary was empowered to perform any of these functions directly or by contract.¹⁰ Payment of claims submitted directly to the Secretary was made by the Office of Direct Reimbursement (ODR) of the Health Care Financing Administration (HCFA).

In 1977 section 1395h, the provision giving providers the right to nominate intermediaries, was amended by the addition of provisions authorizing the Secretary to assign or reassign providers to certain intermediaries if he determined, after applying specified criteria, that the assignment or reassignment would result in the more effective and efficient administration of the Medicare program.¹¹ In 1980 Congress, respond-

⁵ *Id.* §§ 1395x(m) (1976 & Supp. IV 1980).

⁶ *Id.* §§ 1395f(a) & (b), (1395x(m), (o) & (u) (1976 & Supp. IV 1980).

⁷ *Id.* § 1395h(a) (Supp. IV 1980).

⁸ *Id.*

⁹ *Id.* § 1395g (1976 & Supp. IV 1980).

¹⁰ *Id.* § 1395kk(a) (1976).

¹¹ Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub.L.No. 95-142, 91 Stat. 1175, 1198-99 (1977) (codified at 42 U.S.C. §§ 1395h(e)(1), (2), (3) & 1395h(f) (Supp. IV 1980).

ing to concerns over the "wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers,"¹² further amended section 1395h. The 1980 amendment required the Secretary to designate regional intermediaries for freestanding¹³ HHAs electing to use an intermediary.¹⁴ Shortly after the 1980 amendment, the Secretary promulgated the regulation that is the cause of the present controversy.

B. The Contested Regulation

On 8 December 1981 the Secretary, without following the notice and comment requirements of the APA, issued an administrative instruction directing freestanding HHAs to begin using forty-nine government-designated, state-wide intermediaries for all Medicare reimbursement determinations and payments.¹⁵ Under the proposed plan, 864 HHAs were reassigned to new intermediaries.¹⁶ Approximately fifty-four per-

¹² H.R. Rep. No. 1167, 96th Cong., 2d Sess. 368, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5526, 5731-32.

¹³ HHAs may either be affiliated with another provider (such as hospital or rehabilitation center), in which case they are referred to as "provider-based", or they may be "freestanding," in which case they operate without such an affiliation.

¹⁴ Omnibus Budget Reconciliation Act of 1980, Pub.L.No. 96-499, § 930(o), 94 Stat. 2599, 2632 (1980) (codified at 42 U.S.C. § 1395h(e)(4) (Supp. IV 1980)).

¹⁵ The instruction was included in a letter sent directly to all intermediaries, with directions to furnish copies to the HHAs they served.

¹⁶ The other approximately 2,000 HHAs were to deal with their current intermediaries, since those intermediaries had been designated as regional intermediaries.

cent of these 864 were providers who had previously been dealing directly with the Secretary. At the time the instruction issued the Secretary planned to phase-in the proposed reassignments over a period beginning 1 January 1982 and ending 1 October 1982, with transfers becoming effective at the start of the individual HHA's fiscal year. Subsequently, however, the Secretary accelerated the proposed implementation, by requiring that all transfers be effective by 15 March 1982. Soon after the December 1981 instruction issued, the present litigation ensued.

C. The Present Litigation

On 24 December 1981 Appellees, two national associations of HHAs, a corporation which owns and operates forty-eight HHAs, and thirty-seven individual HHAs, filed this action in the district court. Appellees sought to enjoin the Secretary from implementing the reassignment outlined in the December 1981 instruction on the grounds that the instruction violated the Medicare Act, the APA, and the Due Process Clause of the Fifth Amendment. On cross-motions for summary judgment, the district court ruled in Appellees' favor on most of the issues involved.

The court rejected the Secretary's argument that jurisdiction over all but the Appellees' APA claim was precluded by 42 U.S.C. § 405(h), concluding that section 405(h) did not preclude federal question jurisdiction over statutory claims for which no alternative form of judicial review was available.

The court also held in Appellees' favor on the merits, concluding that under the Medicare Act, HHAs which had not previously nominated intermediaries had the right to have Medicare reimbursement determinations and payments made directly by the Secretary. The court further held that the December 1981 instruction did not apply to those HHAs which had elected to deal with an intermediary because it was a rule subject to the notice and comment requirements of the APA, requirements the Secretary failed to follow. Accordingly, the

court enjoined the Secretary from requiring freestanding HHAs to deal with regional intermediaries if they had chosen not to, and ordered that any effort to reassign freestanding HHAs that had elected to use intermediaries be preceded by the agency's compliance with the notice and comment provisions of the APA.¹⁷ This appeal followed.

II. JURISDICTION

Appellees maintain that the district court had jurisdiction to hear all their claims under 28 U.S.C. § 1331, the general grant of federal question jurisdiction. The Secretary counters by arguing that 42 U.S.C. § 405(h), incorporated by reference into the Medicare Act,¹⁸ precludes the district court from exercising section 1331 jurisdiction. Alternatively, the Secretary for the first time argues that if jurisdiction is not precluded by section 405(h), it has been impliedly precluded by Congress' failure expressly to provide for judicial review of claims like the present ones. Because we agree with the district court's interpretation of section 405(h), we hold that jurisdiction over the present action is not barred by this much-litigated preclusion section.¹⁹ We also hold that Congress did not impliedly

¹⁷ The district court dismissed Appellees' Due Process claim because it was an attack on the Secretary's future determination of "reasonable costs" and not on the administrative instruction being challenged and because it was based on the "speculative" possibility that Appellees would not be totally compensated for the costs attributable to the transition. *National Association of Home Health Agencies v. Schweiker*, No. 81-3160, *slip op.* at 8. (D.D.C. 10 March 1982). The parties have not appealed that ruling.

¹⁸ 42 U.S.C. § 1395ii (1976).

¹⁹ This court has decided two cases involving section 405(h). *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978); *Association of American Medical Colleges v. Califano*, 569 F.2d 101 (D.C. Cir. 1977). The section has also spawned numerous litigation in other circuits. *United States v. Sanet*, 666 F.2d 1370 (11th Cir. 1982); *Hopewell Nursing Home v. Schweiker*, 666 F.2d 34

preclude jurisdiction over claims like the present ones by failing expressly to provide for their review.

A. *Jurisdiction Over the Procedural Claims*

Although the Secretary did not object to the exercise of jurisdiction over Appellees' APA claim at the district court level, he has apparently changed his position on appeal, contending that the district court was mistaken in concluding that it had jurisdiction over "any of [Appellees'] claims."²⁰ However, we can easily dispose of the jurisdictional issue with respect to the APA claim by relying on a prior decision of this court.

Section 405(h) of the Social Security Act provides:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who are parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or an officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover any claim arising under this subchapter.²¹

(4th Cir. 1981); *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473 (9th Cir. 1981); *Chelsea Community Hospital, SNF v. Schweiker*, 630 F.2d 1131 (6th Cir. 1980); *Kechijian v. Califano*, 621 F.2d 1 (1st Cir. 1980); *Bussey v. Harris*, 611 F.2d 1001 (5th Cir. 1980); *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir. 1977); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910 (2d Cir. 1976); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir.), cert. denied sub nom. *Faith Hospital Association v. Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976). As noted later, the courts of appeals have been less than consistent in their interpretation of the scope of section 405(h). See text at notes 47-49 *infra*.

²⁰ Appellants' Brief at 13 (emphasis added).

²¹ 42 U.S.C. § 405(h) (1976).

This section was incorporated into the Medicare Act "to the same extent as [it is] applicable."²² The Secretary contends that section 405(h) precludes the district court from exercising jurisdiction over the APA claim raised by Appellees. However, the law in this circuit is to the contrary.

In *Humana of South Carolina, Inc. v. Califano*,²³ this court held that section 405(h) does not bar a claim brought under the APA. The court noted that "in terms [section 405(h)] bars only actions brought to 'recover on any claim' arising under the Medicare Act."²⁴ Thus, the court concluded, when a suit is brought "simply to vindicate an interest in procedural regularity, Section [405(h)] is not summoned into play."²⁵ Finding that holding eminently logical, and discovering that at least one other court of appeals has followed it,²⁶ we see no reason to override it.

The Secretary argues that since *Humana* was decided, Congress has amended the Medicare Act to require that all challenges to reimbursement regulations, whether substantive or procedural, be brought under 42 U.S.C. § 1395oo rather than under 28 U.S.C. § 1331, and that accordingly, section 405(h) now precludes federal question jurisdiction over such claims. However, as we explain later,²⁷ the 1980 amendment referred to did not expand the scope of issues reviewable under section 1395oo, it merely provided expedited review for certain issues arising in reimbursement disputes that are otherwise review-

²² *Id.* § 1395ii (1976).

²³ 590 F.2d 1070 (D.C. Cir. 1978).

²⁴ *Id.* at 1080 (footnote omitted).

²⁵ *Id.* (footnote omitted).

²⁶ *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473, 476 (9th Cir. 1981).

²⁷ See text at notes 39-40, *infra*.

able under the statute. Accordingly, we hold that section 405(h) does not preclude claims challenging the Secretary's compliance with the APA.

B. Jurisdiction Over the Substantive Claim

Jurisdiction over Appellees' challenge to the Secretary's substantive authority to issue the regulation in question is not as easily decided. The Secretary argues that jurisdiction over this claim is precluded by section 405(h). Alternatively, he maintains that Congress has impliedly precluded all judicial review of such claims by expressly providing for judicial review of some Medicare Act claims without expressly authorizing judicial review of claims such as the present one. However, we find both these arguments unpersuasive and hold that the district court had jurisdiction over Appellees' substantive claim.

1. Preclusion of Jurisdiction Under Section 405(h)

The Secretary's first argument is based on the premise that section 405(h) precludes federal question jurisdiction over claims for which the Medicare Act provides alternative routes of review. The Secretary then maintains that Appellees could have brought the present action under the provisions of 42 U.S.C. § 139500 and concludes that jurisdiction under section 1331 is precluded.²⁸ Although we accept the Secretary's first

²⁸ If jurisdiction did exist under section 139500, requiring Appellees to utilize that section would not merely change the basis under which the district court exercised its jurisdiction. It would require Appellees to refrain from attacking the disputed regulation until they filed a cost report with their intermediaries on or before 31 March 1983. Appellees would then be required to file a claim with the Provider Reimbursement Review Board, which would decide the issue. Following a final decision by the Review Board, or a reversal, affirmance, or modification thereof by the Secretary, Appellees could finally press their claim in federal court. Thus, the Secretary's argument is of more than academic interest.

premise, we are unable to agree with his second. Accordingly, we must reject his conclusion.

a. *The availability of judicial review under section 139500.* Section 139500 was enacted in 1972 to provide for review of an intermediary's decision "as to the amount of total program reimbursement due to the provider."²⁹ Under section 139500 initial review of the intermediary's decision is made by the Provider Reimbursement Review Board (PRRB).³⁰ A provider dissatisfied with the PRRB's decision then has the right to obtain judicial review of that decision, or of any reversal, affirmance, or modification thereof by the Secretary, by filing a civil action in federal district court.³¹ We conclude, however, that this route to judicial review is unavailable to Appellees in the present case.

In *Humana* this court noted that "[c]onsideration by the Provider Reimbursement Review Board . . . is [confined] to disputes over the amount properly reimbursable."³² Appellees' substantive claim does not involve a dispute over the amount payable under the Act, nor does it involve Appellees' eligibility for reimbursement. Indeed, Appellees seek no money at all. They merely challenge the *method* of reimbursement, a concern that is not cognizable under section 139500.

The Secretary maintains that Appellees' claims are similar to those which we held were precluded by section 405(h) in *Humana* and in *American Association of Medical Colleges v.*

²⁹ 42 U.S.C. § 139500(a)(1)(A) (1976). Section 139500 review is also available when the intermediary fails to make a final decision in a timely manner, *id.* § 139500(a)(1)(B) & (C), a situation clearly not involved here.

³⁰ *Id.* § 139500(a) (1976).

³¹ *Id.* § 139500(f)(1) (Supp. IV 1980).

³² *Humana*, 590 F.2d at 1081 (footnote omitted).

Califano (AAMC).³³ However, the claims we found precluded in those cases were fundamentally different from that pressed by Appellees in the present litigation. In *Humana* the plaintiff challenged regulations limiting the amount of reimbursement, a challenge “unmistakenly directed at upsetting on the merits the Secretary’s *determination on an element of cost-reimbursement*.”³⁴ We held that such a substantive challenge was precluded by section 405(h) because “*Humana’s fundamental grievance . . . centers on the amount of cost-reimbursement . . . a subject amenable to Review Board adjudication.*”³⁵ In *AAMC* a group of Medicare providers challenged a regulation fixing “*limits on hospital in-patient general routine service costs.*”³⁶ We held that the district court did not have federal question jurisdiction because section 405(h) precluded jurisdiction over “*suits seeking eventual realization of provider-cost reimbursement under the Medicare Act.*”³⁷ Thus, in both *Humana* and *AAMC* the regulations attacked imposed limits on the *amount* of reimbursement. The issues raised in those cases were directly related to a claim for reimbursement. Appellees’ claim, on the other hand, does not directly concern the amount of reimbursement they will receive. As noted above, it concerns the mode of reimbursement.

The Secretary further argues that the only reason Appellees are challenging the instruction is that they fear they will incur compliance costs that will not be fully reimbursed, and that therefore, the substantive claim is one seeking *eventual* realization of provider-cost reimbursement. However, regardless of the Appellee’s motivation for bringing this suit, reimbursement is not its ultimate goal. Appellees seek to enjoy the

³³ 569 F.2d 101 (D.C. Cir. 1977).

³⁴ *Humana*, 590 F.2d at 1079 (emphasis added).

³⁵ *Id.* (emphasis added).

³⁶ *AAMC*, 569 F.2d at 104.

³⁷ *Id.* at 107 (emphasis added).

Secretary from changing the method of processing payment claims. Granting the requested relief will not enable Appellees to receive larger reimbursements. As the district court recognized, Appellees "do not seek any type of eventual monetary recovery on a reimbursement claim by this action."³⁸

Finally, the Secretary argues that if claims such as the Appellees' were not previously encompassed by the section 139500 review provisions, they were brought under that section by a 1980 amendment to the Medicare Act. The 1980 amendment allows a provider "to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines . . . that it is without authority to decide the question."³⁹ The Secretary contends that the amendment evidences Congress' intent that claims related in any way to reimbursement disputes be challenged pursuant to section 139500 rather than under section 1331. However, the legislative history behind the amendment reveals that it was not intended to broaden the scope of issues judicially reviewable under section 139500.⁴⁰ The 1980 amendment merely permits expedited judicial review of certain issues arising in reimbursement disputes *otherwise reviewable under the statute*. As explained above, the present claim cannot be characterized as a reimbursement dispute. Therefore, the 1980 amendment does not alter the justiciability of this claim under section 139500.

Because there is no alternative form of judicial review available to Appellees under the Medicare Act, the Secretary's first

³⁸ *Schweiker*, slip op. at 10.

³⁹ 1980 Omnibus Budget Reconciliation Act, Pub. L. No. 96-499, § 955, 94 Stat. 2599, 2647 (1980).

⁴⁰ See H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394, reprinted in 1980 U.S. Code Cong. & Ad. News 5526, 5757.

argument would appear to fail. However, because that argument is premised on the assumption that section 405(h) precludes only those claims for which the Medicare Act provides an alternative form of judicial review, the Secretary's conclusion would still be correct if section 405(h) barred claims arising under the Medicare Act for which no alternative form of judicial review is available. Thus, we must next determine the scope of section 405(h)'s preclusion.⁴¹

b. *The scope of section 405(h).* In *Weinberger v. Salfi*⁴² the Supreme Court held that section 405(h) precluded the exercise of federal question jurisdiction over a constitutional challenge to various provisions of the Social Security Act. However, the Court found that the challenge could be brought under a separate provision of the Social Security Act,⁴³ thereby implying that the result might have been different had no alternative form of judicial review been available.⁴⁴ Since *Salfi* the various courts of appeals have grappled with the issue of whether section 405(h) precludes federal question jurisdiction when no alternative form of judicial review is available.⁴⁵ Every court that has considered the issue has agreed that section 405(h) should be read so as to permit *some* avenue of judicial review for *constitutional* claims.⁴⁶ However, the result has not been so

⁴¹ On appeal the Secretary addressed this issue only in a footnote, Appellants' Brief at 24 n.22, despite the district court's observation that its resolution was "far from clear." *Schweiker, slip op.* at 5.

⁴² 422 U.S. 749 (1975).

⁴³ 42 U.S.C. § 405(g) (Supp. IV 1980). This provision, unlike section 405(h), was not incorporated into the Medicare Act. *See* 42 U.S.C. § 1395ii (1976).

⁴⁴ *Salfi*, 422 U.S. at 762.

⁴⁵ *See* cases cited in note 19, *supra*.

⁴⁶ *Bussey v. Harris*, 611 F.2d 1001, 1005 (5th Cir. 1980); *Hospital San Jorge, Inc. v. U.S. Secretary of HEW*, 598 F.2d 684, 686 (1st Cir. 1979); *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 571 F.2d 328, 331-32 (5th Cir.), *cert. denied*, 439 U.S. 893 (1978); *Trinity*

harmonious when the same courts have considered the effect of section 405(h) on otherwise non-reviewable *statutory* claims.

Three circuit courts have held that section 405(h) precludes all federal courts from exercising jurisdiction over claims arising under the Medicare Act even when no alternative form of judicial review is available.⁴⁷ Two courts of appeals have held that section 405(h) precludes the exercise of federal question jurisdiction over claims for which no alternative form of judicial review is available, but only after concluding that the Court of Claims had jurisdiction over such claims.⁴⁸ Finally, two circuit courts, the Sixth and the Second, along with the Court of Claims, have held that section 405(h) is not a bar to claims arising under the Medicare Act when there is no alter-

Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc., 570 F.2d 660, 667 (7th Cir. 1977); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910, 913-14 (2d Cir. 1976); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283, 291-93 (8th Cir.), *cert. denied sub nom. Faith Hospital Association v. Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976).

⁴⁷ *Kechijian v. Califano*, 621 F.2d 1 (1st Cir. 1980); *Hospital San Jorge, Inc. v. U.S. Secretary of HEW*, 598 F.2d 684, 686 (1st Cir. 1979); *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 570 F.2d 660, 666 (7th Cir. 1977); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283, 287-89 (8th Cir. 1976). The Seventh Circuit noted that a federal court might have jurisdiction to review a decision by the Secretary if it were "in direct conflict with an express mandate of the Medicare Act." *Trinity Memorial*, 570 F.2d at 666 n.9.

⁴⁸ *Drennan v. Harris*, 606 F.2d 846, 850 (9th Cir. 1979); *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 571 F.2d 328, 332 (5th Cir.), *cert. denied*, 439 U.S. 893 (1978).

native form of judicial review available.⁴⁹ We agree with the district court that the view espoused by the Sixth and Second Circuits and the Court of Claims is the correct one.

We start with the well established principle that an agency bears a "heavy burden of overcoming the strong presumption that Congress did not mean to prohibit all judicial review" of an agency decision.⁵⁰ Thus, "only upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review."⁵¹ We conclude that the Secretary has failed to meet this heavy burden.

First, the Secretary has cited no legislative history which indicates that Congress intended to preclude jurisdiction over claims which there was no alternative form of judicial review. Indeed, section 405(h) was incorporated into the Medicare Act only to the extent it was applicable.⁵² "[T]he entire thrust of the section is to prevent claimants who seek judicial review of their claims for benefits from bypassing the specific procedural requirements provided by Congress in the various acts."⁵³ Thus, "[t]he subsection does not have a meaningful application in a case where no statutory review mechanism is available."⁵⁴

Second, precluding review of claims like the present one does not further the policy which led Congress to incorporate

⁴⁹ *Chelsea Community Hospital, SNF v. Michigan Blue Cross Association*, 630 F.2d 1131, 1134-36 (6th Cir. 1980); *United States v. Aquavella*, 615 F.2d 12, 20-21 (2d Cir. 1979); *Whitecliff, Inc. v. United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 960 (1977).

⁵⁰ *Dunlop v. Bachowski*, 421 U.S. 560, 567 (1975).

⁵¹ *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140 (1967). See also *Rusk v. Court*, 369 U.S. 367, 379-80 (1962).

⁵² 42 U.S.C. § 1395ii (1976).

⁵³ *Aquavella*, 615 F.2d at 19.

⁵⁴ *Chelsea Community Hospital*, 630 F.2d at 1135.

section 405(h) into the Medicare Act. As the Eighth Circuit noted, Congress adopted section 405(h) because permitting

[j]udicial review of the amount of all Medicare payments would bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services . . . These charges are subject to extensive and complicated statutory guidelines and regulations . . . Determining the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.⁵⁵

These concerns are not present when actions like the present one are brought to challenge secretarial action unrelated to reimbursement disputes.⁵⁶ Finding no clear and convincing evidence to the contrary, we conclude that Congress, by incorporating section 405(h) into the Medicare Act to the extent applicable, did not intend to preclude judicial review of claims for which no alternative form of judicial review was available. Accordingly, we reject the Secretary's argument that section 405(h) precludes jurisdiction in the present case.

2. *Implied Preclusion of Jurisdiction*

In his reply brief the Secretary argues that even if jurisdiction is not precluded by section 405(h), it is nevertheless barred in view of Congress' express delineation of the kinds of

⁵⁵ *St. Louis University*, 537 F.2d at 289.

⁵⁶ We do not mean to imply that a federal court may disregard section 405(h) anytime the concerns expressed above are not present. To do so would be to disregard the Supreme Court's statement that "the third sentence of § 405(h) is more than a codified requirement of administrative exhaustion." *Weinberger v. Salfi*, 422 U.S. 749, 757 (1975). We note that the articulated concerns are not implicated by allowing courts to decide cases such as the present one only to show that our reading of the statute is reasonable. When section 405(h) does apply, its effect cannot be avoided by resort to exceptions to the administrative exhaustion requirement. *See id.*

claims which may be reviewed under the Medicare Act. Relying on *United States v. Erika, Inc.*,⁵⁷ the Secretary maintains that since Congress expressly made certain types of cases reviewable under the Medicare Act, issues not reviewable under the Medicare Act, issues not reviewable under section 1395oo are not reviewable at all. A review of the Supreme Court's decision in *Erika*, however, indicates that the case does not support the Secretary's point of view.

In *Erika* a physician brought a claim for reimbursement under Part B of the Medicare Act. That part of the Act provides for judicial review of the Agency's determination concerning the physician's *eligibility* for payments, but does not contain a provision permitting review of the Agency's determination of the *amount* of reimbursement. The Supreme Court noted that Congress had provided judicial review for both eligibility and amount determination under Part A of the Medicare Act, but had provided for judicial review of only eligibility determinations under Part B.⁵⁸ The Court also examined statements from the legislative history of the Medicare Act and subsequent amendments which clearly indicated an intent to restrict the appealability of amount determinations under Part B.⁵⁹ In the face of these "expressions of legislative intent [which] unambiguously support our reading of the statutory language," the Court concluded that judicial review of amount determinations under Part B of the Act was precluded.⁶⁰

The reasoning utilized by the Supreme Court in *Erika* does not apply to the present claim which was brought under Part A of the Medicare Act. As noted earlier, the general presumption

⁵⁷ 50 U.S.L.W. 4399 (U.S. 20 April 1982).

⁵⁸ *Id.* at 4401.

⁵⁹ *Id.* at 4401-02 & nn.11-13.

⁶⁰ *Id.* at 4402.

is in favor of judicial review.⁶¹ In *Erika* the government overcame this presumption by presenting clear and convincing evidence that Congress intended to preclude judicial review. The Secretary argues that the precisely drawn review provisions of Part A,⁶² coupled with the omission of an express provision of judicial review for claims like the present one, provides the requisite clear and convincing evidence of Congressional intent to preclude judicial review. However, "[t]he mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to review is too important to be excluded on such slender and indeterminate evidence of legislative intent." ⁶³ Where, as here, the statutory language and legislative history is devoid of even the slightest intimation that Congress intended to preclude judicial review over the issues raised by Appellees, the mere fact that other types of issues are expressly reviewable under the Medicare Act does not constitute the clear and convincing evidence needed to overcome the presumption in favor of judicial review. Therefore, we reject the Secretary's second argument, and hold that the district court properly exercised its jurisdiction in the present case.

⁶¹ *Dunlop v. Bachowski*, 421 U.S. 560, 567 (1975); *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140 (1967); *Rusk v. Court*, 369 U.S. 367, 379-80 (1962).

⁶² At the inception of the Medicare Act in 1965, part A providers were entitled to judicial review only on issues relating to their eligibility as qualified providers. 42 U.S.C. § 1395ff(c) (1976). See S. Rep. No. 404, 89th Cong., 1st Sess. 54-55, reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 1995. In 1972 and again in 1974, the Act was amended to permit providers to obtain judicial review of amount determinations as well. See 42 U.S.C. § 1395oo(a)-(e) (1976).

⁶³ *Abbott Laboratories*, 387 U.S. at 141 (quoting L. Jaffe, *Judicial Control of Administrative Action* 357 (1965)).

III. THE SECRETARY'S AUTHORITY TO REQUIRE THAT HHAs DEAL WITH REGIONAL INTERMEDIARIES

The central issue in this case concerns the Secretary's authority to require freestanding HHAs to submit their claims to designated regional intermediaries for processing and payment. The resolution of this issue requires us to determine the relationship among three provisions of the original Medicare Act, sections 1395g, 1395h, and 1395kk.

Section 1395g of the Medicare Act provides:

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid at such time or times as the Secretary believes appropriate (but not less than monthly) . . . the amounts so determined . . .⁶⁴

Appellees argue, and the district court held that this section gives HHAs the right to have their reimbursement determinations and payments made directly by the Secretary. Appellees maintain that the Secretary is authorized to delegate this responsibility to an intermediary only if the HHA elects to have payments made through an intermediary under section 1395(a).⁶⁵ The Secretary, on the other hand, contends that

⁶⁴ 42 U.S.C. § 1395g(a) (1976).

⁶⁵ *Id.* § 1395h(a) (Supp. IV 1980). In pertinent part the statute provides:

If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization . . . of the amount of the payments required pursuant to this part to be made to such providers . . . and for the making of such payments by such agency or organization to such providers . . .

whatever right is conferred on an HHA by section 1395g is limited by his authority under section 1395kk to "perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement . . . as the Secretary may deem necessary."⁶⁶ Thus, under the Secretary's view, section 1395g merely requires the Secretary periodically to determine the amount due a provider and to pay that amount at least monthly. Section 1395kk then gives him the authority to contract out those reimbursement functions as he deems necessary.

The Secretary's interpretation of the statute appears to be the correct one. Since *McCulloch v. Maryland*⁶⁷ it has been a general rule of construction that a government entity empowered to perform a function has the authority to use any reasonable tools and means to carry out that function. Thus, that Congress would authorize the secretary to perform *any* of his Medicare functions, including his reimbursement functions, either directly or indirectly is not at all surprising. The need for such flexibility is obvious when one considers the numerous responsibilities assigned to the Secretary under the Medicare Act.

Moreover, the Secretary's contention that section 1395kk empowers him to contract out his reimbursement responsibili-

⁶⁶ *Id.* § 1395kk(a) (1976). In full the statute provides:

Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974, the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

⁶⁷ 17 U.S. (4 Wheat.) 316 (1819).

ties is bolstered by the Senate Finance Committee's Report on the Medicare Act, which states:

Under the [proposed bill], nominated organizations having experience with cost reimbursement could determine the amount of payments and make such payments whether under part A or part B. *In the absence of a suitable nominated organization, the Secretary could contract out all or part of this service or handle the function directly.*⁶⁸

The House also recognized the broad scope of section 1395kk, noting in its report:

Section [1395kk] provides that, except as otherwise stated, the programs established by title XVIII are to be administered by the Secretary, who may perform *any* of his functions directly or by contract.⁶⁹

Therefore, the clear and reasonable language of the Act, reinforced by appropriate statements from its legislative history, appears to give the Secretary the unequivocal right to designate intermediaries to perform his reimbursement functions and to require that HHAs deal with those intermediaries.

The district court gave three reasons for not adopting this seemingly reasonable interpretation. First, the court found that Congress had repeatedly expressed its understanding that providers had the unqualified option of dealing directly with the Secretary. Second, the structure of subsequent amendments to the original Medicare Act indicated to the

⁶⁸ S. Rep. No. 404, 89th Cong., 1st Sess. 53, *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 1994 (emphasis added). Appellees argue that the quoted language refers only to the situation in which a provider elects to use an intermediary, but fails to nominate a suitable one. However, nothing in the report suggests that the language should be read so narrowly.

⁶⁹ H.R. Rep. No. 213, 89th Cong., 1st Sess. 174 (1965) (emphasis added).

court that Congress did not believe that the Secretary was empowered to appoint intermediaries for HHAs wishing to deal directly with the Secretary. Finally, the court was persuaded by the Secretary's apparent acquiescence in a 1966 Assistant General Counsel opinion stating that the Secretary did not have the right to designate an intermediary for a provider who did not elect to be served by one. Appellees urge us to adopt the district court's reasoning.⁷⁰ However, after examining that reasoning carefully, we remain convinced that there is no need to deviate from the reasonable interpretation advanced by the Secretary.

A. Congressional Expressions Concerning a Provider's Right to Deal Directly With the Secretary

The district court was influenced by what it described as "continuing expressions of Congressional understanding that Medicare providers have the option to receive payment from the government directly."⁷¹ However, a close examination of the context in which these expressions were made reveals that Congress was not addressing the issue presently being considered. The statements at most indicate that providers may at times elect to deal with the Secretary. They in no way evidence an intent to abrogate the Secretary's right to conduct his business through an intermediary if *he* so chooses.

⁷⁰ Appellees also argue that the lower court's ruling was correct because as a matter of statutory construction the specific features of section 1395g override the more general provisions of section 1395kk. Rather than quibble over which section is more specific, we merely note that the interpretation we adopt is reasonable and supported by the relevant legislative history. It also gives effect to both provisions in question. In such circumstances, the rule of statutory construction cited by Appellees is not particularly useful.

⁷¹ *Schweiker, slip op.* at 15.

The first statement relied upon by the district court is excerpted from both the Senate and House reports on the original Medicare Act.

A member of an association whose nominated organization or agency had been selected as a fiscal intermediary could elect to receive payment from another intermediary which had been selected (provided that the other organization or agency agrees) or could elect to deal directly with the Secretary.⁷²

It is clear from the context of this statement⁷³ that the part of the Medicare Act being discussed is section 1395h(d).⁷⁴ Section 1395h(d) gives a provider who is a member of an association the right to refuse to use an intermediary chosen by the associa-

⁷² S. Rep. No. 404, 89th Cong., 1st Sess. 52, *reprinted in* 1965 U.S. Code Cong. & Ad News 1943, 1993; H.R. Rep. No. 213, 89th Cong., 1st Sess. 45 (1965).

⁷³ The statement is in a portion of the report discussing "General provisions relating to the basic and voluntary supplemental plans," so it does not expressly refer to a particular section. Nevertheless, the entire statement refers to providers who belong to an association which has elected an intermediary to which a member of the association objects. The similarity between the quoted language and the statements used to describe the effect of section 1395h(d) further indicate that the quoted language refers to that section. See text at note 75, *infra*.

⁷⁴ 42 U.S.C. § 1395h(d) (1976). In full the section provides:

If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such organization agree to it.

tion. Thus, the quoted language merely indicates that a member of an association cannot be bound by the "association's choice of an intermediary. It in no way intimates that the *Secretary* cannot make such a choice.

The next reference relied upon by the district court is likewise an explanation of section 1395h(d). Explicitly referring to that section, both Committees noted:

Section [1395h(d)] provides that if the nomination of an [intermediary] is made by a group or association of providers of services, it will not be binding on members of such group or association which notify the Secretary of their election to that effect. . . . Any provider which has withdrawn its nomination (and any provider which has not made a nomination) may elect to receive payments either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary. . . .⁷⁵

Again, the statement merely indicates that the association's choice of an intermediary is not binding on its members. It does not negate the Secretary's authority to designate intermediaries if in his judgment that would be the best way to administer his responsibilities.

The final expressions of Congressional intent which the district court found persuasive were made in 1977 and 1980, when Congress amended section 1395h.⁷⁶ These expressions, like the previous ones, do not cast any doubt on the Secretary's right to conduct his business through an intermediary.

In 1977 several provisions were added to section 1395h. The House Committee on Interstate and Foreign Commerce set

⁷⁵ S. Rep. No. 404, 89th Cong., 1st Sess. 164-65, *reprinted in* U.S. Code Cong. & Ad. News 1943, 2104; H.R. Rep. No. 213, 89th Cong., 1st Sess. 147-48 (1965).

⁷⁶ The substance and effect of these amendments is discussed later. See text at notes 80-85, *infra*.

forth their understanding of the pre-amendment law as follows:

Under part A of medicare, groups or associations of providers of services, *i.e.*, . . . home health agencies, can nominate an organization to act as a fiscal intermediary between the providers and the Secretary. An individual member of an association or group of providers which has nominated one organization as intermediary may select some other organization as its intermediary if this is satisfactory to the organization and the Secretary, or alternatively, it may elect to deal with the Secretary.⁷⁷

This again appears to be an explanation of section 1395h(d). It therefore does not justify imposing any limits on the language of section 1395kk.

In 1980 when section 1395h was again amended, this time by adding a provision requiring the Secretary to designate regional intermediaries for freestanding HHAs electing to use an intermediary, the Conference Committee Report contained the following language, which Appellees assert clearly evidences Congress' understanding that HHAs had the unlimited right to deal directly with the Secretary. "In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration."⁷⁸ As discussed in the next section,⁷⁹ this language merely indicated that the 1980 amendment did not require the Secretary to designate regional intermediaries for all freestanding HHAs, thereby preserving the Secretary's discretion to permit HHAs to deal directly with him. Nothing in the amendment or the quoted language

⁷⁷ H.R. Rep. No. 393, Part I, 95th Cong., 1st Sess. 68 (1977); H.R. Rep. No. 393, Part II, 95th Cong., 1st Sess. 76 (1977).

⁷⁸ H. Rep. No. 1479, 96th Cong., 2d Sess. 129 (1980).

⁷⁹ See text notes 84-85, *infra*.

indicates that the Secretary's power under section 1395kk was to be limited by some overriding right of the provider to deal directly with the Secretary.

Thus, nothing in the Congressional expressions relied upon by the district court indicates that section 1395kk is to be read as anything less than an authorization for the Secretary to perform his reimbursement functions through an intermediary. Nor do these expressions contain anything indicating that a provider has an unqualified right under section 1395g to deal directly with the Secretary. Therefore, these expressions do not persuade us to alter our view that section 1395kk authorizes the Secretary to issue the regulation in question.

B. The Effect and Implication of the 1977 and 1980 Amendments

Both parties point to the structure and language of the 1977 and 1980 amendments as support for their divergent conclusions. However, we find the two amendments largely irrelevant to the question at hand because they neither increase nor limit the Secretary's power under section 1395kk.

The 1977 amendment authorized the Secretary to "assign or reassign any provider of services" to an intermediary if he determined, after applying certain standards, criteria and procedures, "that such designation would result in more effective and efficient administration" of the Medicare program.⁸⁰ Contrary to the Secretary's argument that this amendment confirmed or increased his authority to contract out his provider reimbursement functions, we conclude that the amendment merely authorized the Secretary to appoint new intermediaries for providers who had previously elected to use one.

⁸⁰ Medicare-Medicaid and Anti-Fraud and Abuse Amendments of 1977, Pub. L. No. 95-142, 91 Stat. 1175, 1199 (1977) (codified at 42 U.S.C. §§ 1395h(e)(1), (2), (3), & 1395h(f) (Supp. IV 1980)).

The 1977 amendment, entitled "The Medicare-Medicaid Antifraud and Abuse Amendment," was designed to give the Secretary power to deal with the potential problems caused by allowing a provider to choose his own intermediary. The providers' power to nominate or dismiss an intermediary, it was feared, had caused some intermediaries to be overly generous in determining the amounts due a provider under the Act.⁸¹ The amendment therefore required the Secretary to develop precise and uniform standards and criteria for evaluating an intermediary's performance, so that the Secretary would know when an intermediary's performance was unsatisfactory.⁸² In such situations the Secretary was authorized to assign the provider to a new intermediary. The inclusion of the term "*assign or reassign*" seems to refer to providers who nominate an intermediary whose performance has already been judged unsuitable, and not to providers who are dealing with the Secretary. This interpretation is consistent with the structure of the amendment since the new provisions were tacked onto section 1395h, the section giving providers the right to nominate an intermediary.⁸³

The 1977 amendment did not, therefore, increase the Secretary's authority to require an HHA to deal with an intermediary against his will, a power the Secretary already possessed under section 1395kk. But neither did it limit that power. The amendment simply provided the Secretary with an additional tool for dealing with potential intermediary provider collusion.

Similarly, the 1980 amendment did not affect the Secretary's section 1395kk power one way or the other. That legislation provided: "[T]he Secretary shall designate regional agencies or

⁸¹ See H.R. Rep. No. 393, Part I, 95th Cong., 1st Sess. 68-69 (1977); H.R. Rep. No. 393, Part II, 95th Cong., 1st Sess. 76-77 (1977).

⁸² H.R. Rep. No. 393, Part I, 95th Cong., 1st Sess. 69 (1977); H.R. Rep. No. 393, Part II, 95th Cong., 1st Sess. 77 (1977).

⁸³ 42 U.S.C. § 1395h(a) (Supp. IV 1980).

organizations which have entered into an agereement with him under this section to perform functions under such agreement with respect to [freestanding] home health agencies . . . in the region."⁸⁴ Despite this seemingly mandatory language, it is clear that the amendment did not require the Secretary to assign all freestanding HHAs to regional intermediaries. Rather, the amendment only required the Secretary to designate which intermediary an HHA would use if the HHA elected to use one at all. As noted previously, the House conferees were careful to point out that "[i]n requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting dealing with the Health Care Financing Administration."⁸⁵ At the same time, however, the amendment did nothing to limit the Secretary's already existing power to require that HHAs deal with an intermediary if he felt it was proper. Thus, neither the 1977 nor the 1980 amendment affected the Secretary's section 1395kk power to perform his reimbursement tasks through intermediaries, a power that the Secretary can use to issue regulations like the present one.

C. The Effect of the 1966 Assistant General Counsel Opinion

The district court determined that until the issuance of the December 1981 instruction, the Secretary had consistently interpreted the Medicare Act as legally requiring him to deal directly with providers electing to do so. In reaching this conclusion, the court relied on a 1966 opinion of the Depart-

⁸⁴ Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 930(o), 94 Stat. 2599, 2632 (1980) (codified at 42 U.S.C. § 1395h(e) (4) (Supp. 1980)). Provider-based HHAs are to be reassigned only if the Secretary determines, after applying specified criteria, that such assignment will result "in the more effective and efficient administration" of the Medicare program. *Id.*

⁸⁵ H. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 129 (1980).

ment of Health, Education and Welfare's (now Health and Human Services) Assistant General Counsel stating that the Secretary did not have the right to designate an intermediary for a provider who did not want to be served by an intermediary⁸⁶ and by the Secretary's failure to use this power until almost sixteen years later.⁸⁷ While recognizing that the General Counsel's opinion was not binding on the parties, the district court found that, coupled with the Secretary's acquiescence, it was strong evidence that the Secretary's present interpretation of section 1395kk was incorrect.

However, we find that the court erred in placing such great reliance on the actions of the General Counsel and the Secretary. First, when an agency expresses doubts as to its statutory authority to act, such expressions are not binding on a court,

⁸⁶ Memorandum from Melvin Blumenthal, Assistant General Counsel, Health Insurance Division, Department of Health, Education and Welfare (23 Feb. 1966).

⁸⁷ Appellees seek to bolster the district court's conclusion by pointing to the Secretary's own regulations which recognize that providers have the option of dealing directly with the Secretary. 42 C.F.R. § 421.103 (1981); 42 C.F.R. § 421.104 (b)(2) (1981). They argue that the December 1981 instruction was invalid because it violated these regulations, which have the force and effect of law.

However, the regulations cited do not address the Secretary's authority under section 1395kk, they merely recognize that normally under section 1395h a provider can elect to deal with an intermediary or with the Secretary. Even if the regulations did conflict with the December 1981 instruction, Appellees argument would still not be persuasive. This court has recognized that an agency's departure from its regulations or past practice is sanctioned as long as it provides a rational explanation for its actions. *Greater Boston Television Corp. v. Federal Communications Commission*, 444 F.2d 841, 852 (D.C. Cir. 1970), cert. denied, 403 U.S. 923 (1971). If, as we hold, section 1395kk authorizes the Secretary to issue the instruction in question, the Secretary cannot destroy that authority by promulgating regulations.

nor are they due the same deference given to agency determinations requiring special agency competence.⁸⁸ As this Court observed in a similar situation, "[when] the question is simply one of statutory interpretation . . . [calling] largely for the exercise of historical analysis and logical and analogical reasoning, it is the everyday staple of judges as well as agencies."⁸⁹ Moreover, the 1966 Assistant General Counsel's opinion did not take into account the legislative history which supports the Secretary's present position.⁹⁰ Further, subsequent opinions issued by the same office expressly recognized the Secretary's power to require HHAs to deal with intermediaries.⁹¹ Thus, this isolated opinion questioning the Secretary's statutory authority is not enough to persuade us that we should ignore the otherwise clear language of section 1395kk.

Nor is the Secretary's fifteen-year failure to utilize his section 1395kk power determinative. As the Supreme Court explained in a similar situation:

The fact that powers long have been unexercised well may call for close scrutiny as to whether they exist; but if granted, they are not lost by being allowed to lie dormant, any more than nonexistent powers can be prescribed by

⁸⁸ *National Petroleum Refiners Association v. Federal Trade Commission*, 482 F.2d 672, 694 (D.C. Cir. 1973), *cert. denied*, 415 U.S. 951 (1974).

⁸⁹ *Id.*

⁹⁰ S. Rep. No. 404, 89th Cong., 1st Sess. 53, *reprinted in*, 1965 U.S. Code Cong. & Ad. News 1994; H.R. Rep. No. 213, 89th Cong., 1st Sess. 174 (1965) (discussed in text accompanying notes 68-69, *supra*).

⁹¹ Memorandum from Juan A. del Real, General Counsel, Department of Health and Human Services 4, 6-7 (11 Jan. 1982); Memorandum from Hank Eagles, Office of General Counsel, Health Care Financing Division, Department of Health and Human Services 5-6 (Dec. 10, 1980).

an unchallenged exercise. We know that unquestioned powers are sometimes unexercised from lack of funds, motives of expediency, or the competition of more important concerns.⁹²

The Secretary's authority to contract out his reimbursement responsibilities did not dwindle away over time as he chose not to use it. Congress conferred that authority upon the Secretary and only Congress could withdraw it. Neither the Office of General Counsel by its opinions, nor the Secretary by his inaction could diminish that authority in the least.

Because we find that Congress in 1965 chose to give the Secretary the power to contract out his reimbursement responsibilities, we hold that the Secretary may now use that power to require freestanding HHAs to seek reimbursement determinations and payments through an intermediary. However, when utilizing that power the Secretary must comply with the procedural requirements imposed by law. It is to those requirements that we now turn our attention.

IV. THE SECRETARY'S COMPLIANCE WITH THE APA

Section 553 of the APA outlines the procedures an agency must follow when promulgating rules. Most notably, the agency is required to provide the public with general notice of its intent to act and to afford all interested parties an opportunity to comment on the proposed action.⁹³ The Secretary in the

⁹² *United States v. Morton Salt Co.*, 338 U.S. 632, 647-48 (1950). See also *Warner-Lambert Co. v. Federal Trade Commission*, 562 F.2d 749, 759 (D.C. Cir. 1977), *cert. denied*, 435 U.S. 950 (1978).

⁹³ In pertinent part, the section provides:

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and nature of public rule making proceedings;

present litigation does not contest the district court's ruling that the December 1981 instruction was a rule within the meaning of the APA.⁹⁴ Nor does he dispute the court's finding that he failed to comply with the notice and comment provisions of section 553. However, the Secretary maintains that his actions were proper because the December 1981 instruction was a rule of agency procedure exempt from section 553's

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

5 U.S.C. § 553(b) & (c) (1976).

⁹⁴ The APA defines a rule as

the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates,

notice and comment requirements.⁹⁵ Thus, the procedural validity of the Secretary's actions depends on whether the December 1981 instruction can be brought within this "limited" exception.⁹⁶ We hold that it cannot.

Exceptions to the notice and comment provisions of section 553 are to be recognized "only reluctantly."⁹⁷ Otherwise, the salutary purposes behind the provisions would be defeated. The notice and comment requirements were included in the APA for two main reasons. First, "to reintroduce public participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies."⁹⁸ And second, to "assure[] that the agency will have before it the facts and information relevant to a particular administrative problem, as well as suggestions for alternative solutions."⁹⁹ This dual purpose of fairness and agency self-education is advanced if "[e]xceptions [are] recognized only where the need

wages, corporate or financial structures or reorganization thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing.

5 U.S.C. § 551(4) (1976).

⁹⁵ Section 553(b) (A) provides: "Except when a notice or hearing is required by statute, this subsection does not apply—to interpretative rules, general statements of policy or *rules of agency organization, procedure, or practice* . . ." 5 U.S.C. § 553(b)(A) (1970) (emphasis added).

⁹⁶ *Batterton v. Marshall*, 648 F.2d 694, 701 (D.C. Cir. 1980).

⁹⁷ *Humana*, 590 F.2d at 1082.

⁹⁸ *Batterton*, 648 F.2d at 703 (footnote omitted). See also *Pickus v. United States Board of Parole*, 507 F.2d 1107, 1112 (D.C. Cir. 1974).

⁹⁹ *Guardian Federal Savings & Loan Association v. Federal Savings & Loan Insurance Corp.*, 589 F.2d 658, 662 (D.C. Cir. 1978). See also *Brown Express, Inc. v. United States*, 607 F.2d 695, 701 (5th Cir. 1979); *Pickus v. United States Board of Parole*, 507 F.2d 1107, 1112 (D.C. Cir. 1974); *Texaco, Inc. v. Federal Power Commission*, 412 F.2d 740, 744 (3d Cir. 1969).

for public participation is overcome by good cause to suspend it, or where the need is too small to warrant it."¹⁰⁰ Therefore, the "exception of section 553(b)(A) . . . does not extend to those procedural rules that depart from existing practice and have a substantial impact on those regulated."¹⁰¹ Or, to use the words of this court, "[t]he exemption [for rules of agency procedure] cannot apply . . . where the agency action trenches on substantive rights and interests."¹⁰²

The December 1981 instruction does substantially affect the rights and interests of freestanding HHAs. Although we have held that these HHAs do not have an unlimited statutory right to deal directly with the Secretary, it is undisputed that for sixteen years freestanding HHAs had the option of choosing to deal with the Secretary or with an intermediary. Thus, freestanding HHAs had at least a qualified right to choose with whom they dealt. The December 1981 instruction foreclosed that option, eliminating the qualified right. Furthermore, the elimination of this right will cause freestanding HHAs great expense and inconvenience. Appellees presented uncontradicted evidence that the transfer will cost an estimated \$10 million to \$30 million. Many HHAs will be required to change or scrap electronic billing systems which have been designed to interface with equipment used by the Secretary. Numerous HHAs will be required to train and re-educate employees to implement the new system and operate within the guidelines of the new intermediary. This potential inconvenience was exacerbated by the Secretary's decision to speed up implementation of the transfer to 10 March 1982. The disruption caused by the transfer may not be great enough to persuade the Secretary to rescind the instruction, but the potential impact is such that the fairness element of section 553 requires that the

¹⁰⁰ *Batterton*, 648 F.2d at 704 (footnote omitted).

¹⁰¹ *Brown Express, Inc. v. United States*, 607 F.2d 695, 702 (5th Cir. 1979).

¹⁰² *Batterton*, 648 F.2d at 708 (footnote omitted).

HHAs involved be given a chance to present their case to the Secretary before he acts.

In addition, other decisions made by the Secretary in the December 1981 instruction were such that he could have benefited from the HHA's viewpoint. The December 1981 instruction not only foreclosed freestanding HHAs from dealing directly with the Secretary, it also delineated the regions to be served by each intermediary and designated which intermediary would be chosen as the intermediary for each region. It is hard to image that HHAs, which had been dealing with the various intermediaries and working with the various intermediaries and working with Medicare system for years, would not be able to provide the Secretary with valuable information concerning the most efficacious manner in which the regions could be organized and insights about the various organizations which might be chosen as regional intermediaries.

Thus, compliance with the notice and comment requirements of section 553 would not only result in increased fairness to freestanding HHAs, it would also enable the Secretary to receive valuable information concerning the various issues involved before he chose his course of direction. In such circumstances, the procedural exception to section 553 cannot apply.¹⁰³ As this court has previously observed:

Congress was alert to the possibility that these exceptions might, if broadly defined and indiscriminately used, defeat the section's purpose. Thus, the legislative history of

¹⁰³ The Secretary argues that our decision is controlled by our prior decision in *Guardian Federal Savings & Loan Association v. Federal Savings & Loan Insurance Corp.*, 589 F.2d 658 (D.C. Cir. 1978). In *Guardian* this court held that a rule requiring that the audit of federal savings and loan institutions be performed by private auditors rather than by FSLIC was exempt from the notice and comment provisions of section 553. However, that case is distinguishable. First, unlike HHAs, the Savings and Loans involved in *Guardian* never had the freedom to choose who audited them. Thus, no right was eliminated by the Secretary's action. Second, as pointed out above, the December 1981 instruction did more than foreclose

the section is scattered with warnings that various of the exceptions are not to be used to escape the requirements of section 553. [Citations omitted]. Further, the Senate Committee responsible for considering the APA concluded its report by investing courts with a "duty . . . to prevent avoidance of the requirements of the bill by any manner or form of indirection" ¹⁰⁴

We would not be true to that duty if we allowed the Secretary to ignore the requirements of section 553 when promulgating rules which, like the present one, substantially affect private parties and resolve important issues without the beneficial input that those parties could provide.

V. CONCLUSION

Wishing to provide the Secretary with the tools he needs to perform his Medicare responsibilities, Congress empowered him to perform those functions either directly or by contract. The Secretary is free to use that power to require HHAs to deal with intermediaries whenever he deems necessary. However, when he chooses to utilize his authority in that manner he must comply with the procedural requirements imposed by the APA. ¹⁰⁵

HHAs from dealing directly with the Secretary, it created regions and designated regional intermediaries, actions that further affected HHAs, and which involved issues on which HHA input would have been valuable. The rule in *Guardian* merely stated that the Secretary would not perform the required audit, it did not designate who would perform it. Finally, the potential impact on the Savings and Loan was not clearly outlined in *Guardian*, where as here Appellees have presented uncontradicted evidence of the potential disruption caused by the December 1981 instruction.

¹⁰⁴ *American Bus Association v. United States*, 627 F.2d 525, 528 (D.C. Cir. 1980).

¹⁰⁵ The district court ordered the Secretary to comply with the notice and comment provisions of section 553 before attempting to *reassign freestanding HHAs who had elected to use an intermediary*. That order should be expanded to require compliance with section 553 before a rule assigning *any* freestanding HHA to an intermediary.

The district court correctly held that it had jurisdiction to decide this case and that the Secretary's actions are subject to the notice and comment requirements of the APA. We affirm those holdings.¹⁰⁵ However, the court erred in the disposition of Appellees' substantive claim and, to that extent, we must reverse.

It is so ordered.

APPENDIX B

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 82-1293

**NATIONAL ASSOCIATION OF HOME
HEALTH AGENCIES, *et al.***

v.

RICHARD S. SCHWEIKER, *et al.*, Appellants

**September Term, 1982
CA 81-03160**

**United States Court of Appeals
for the District of Columbia Circuit**

FILED October 27, 1982

**GEORGE A. FISHER
CLERK**

**Before: Wilkey, Circuit Judge; Robb, Senior Circuit Judge
and Thomas E. Fairchild,* Senior Circuit Judge for
the Seventh Circuit.**

ORDER

Upon consideration of appellees' motion for stay of mandate pending application for certiorari, of appellants' opposition and of appellees' reply to appellants' opposition, it is

ORDERED, by the Court, that appellees' aforesaid motion for stay of mandate is granted and the Clerk is directed not to

issue the mandate herein for a period of thirty (30) days from the date of this order.

Per Curiam

For the Court:

George A. Fisher
GEORGE A. FISHER
Clerk

RECEIVED

October 28, 1982

WEISSBURG & ARONSON INC.

*Sitting by designation pursuant to Title 28 U.S.C. § 294(d).

APPENDIX C
United States District Court

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 81-3160

**NATIONAL ASSOCIATION OF HOME
HEALTH AGENCIES, et al. Plaintiffs,**

v.

RICHARD S. SCHWEIKER, et al., Defendants.

FILED

March 10, 1982

JAMES F. DAVEY, Clerk

MEMORANDUM OPINION

Plaintiffs in this action are two national associations of home health agencies (HHAs) who bring the cause on behalf of their member agencies which participate in the Medicare program, a corporation which owns and operates 48 home health agencies, and 37 individual home health agencies which participate in the Medicare program. HHAs provide nursing and other therapeutic services as well as certain medical supplies to home-bound individuals, most of whom are covered by the Medicare program by virtue of the fact that they are aged or disabled. The Medicare Act entitles plaintiffs to be reimbursed for the "reasonable cost" of covered home health services provided to Medicare beneficiaries. 42 U.S.C. § 1395f, *et seq.*

On December 8, 1981, defendants issued an administrative instruction (Pltfs.' Ex. 2) which compels plaintiffs to seek Medicare reasonable cost determinations and reimbursement from government-designated regional intermediaries. Private organizations, often health insurance companies such as Blue

Cross, serve as intermediaries. Previously, plaintiffs had the option, which most of them selected, to have determinations made by and receive payment directly from the federal government through its Office of Direct Reimbursement (ODR). They seek to enjoin implementation of the instruction on the grounds that it abrogates their statutory and regulatory rights to receive payment directly from the government; that the intermediaries were designated without application of the proper statutory and regulatory standards, criteria and procedures to assure the effective and efficient administration of Medicare payments; and that the new policy is a substantive rule which was not promulgated in accordance with the rulemaking requirements of the Administrative Procedures Act (APA). Plaintiffs also seek an order requiring defendants to make ODR available to health care providers who do not wish to receive Medicare reimbursement determinations and payment through an intermediary, and to enjoin the instruction as it applies to HHAs who previously received reimbursement through intermediaries of their choice and are now required to transfer to the designated regional intermediaries. Although plaintiffs admit that defendants have the statutory authority to designate the intermediaries for those HHAs who choose to be served by an intermediary rather than ODR, they contend that the designation of intermediaries here did not comply with statutory and regulatory requirements, and should have been promulgated in accordance with APA rulemaking procedures.

Plaintiffs originally sought a preliminary injunction, claiming irreparable harm because of increased costs. Costs alleged are based on the necessity to abandon billing systems in which considerable investment has been made and develop different systems to meet the specifications of the new designated intermediaries; retrain and re-educate employees to implement and operate the new billing systems and function within the guidelines of the regional intermediary; change the types of forms used by intermediaries for bill processing; and for agencies that serve patients in more than one state, the necessity to implement different systems for the regional intermediaries in

each state. Although defendants have represented that providers like the plaintiffs can seek adjustments in their reimbursements to compensate for any reasonable costs incurred due to the transition, they were unable to reach a stipulation that could allay plaintiffs' fear that all of their actual costs will not be reimbursed. Plaintiffs contend that the government's plan to reimburse costs of the transition only proportionally to the percentage of Medicare patients in the facility's clientele unfairly fails to compensate expenses which are 100% attributable to the Medicare program. They further assert that since HHAs typically operate with few assets or cash reserves, non-reimbursed costs or an interruption in cash flow during the transition could threaten their very existence. Interruptions in cash flow are likely to occur, they allege, and in fact are occurring to some of the agencies which made the transition as of January 1 of this year, because the new intermediaries are not now equipped to take over the services of ODR or other intermediaries and perform efficiently and effectively.

The parties reached an agreement whereby plaintiffs would abandon their request for a preliminary injunction, incorporating the arguments from that motion into a motion for summary judgment, recognizing that to accommodate the exigencies the case would be decided on cross motions for summary judgment no later than March 10, 1982.

Although the transition to the new regional intermediaries was originally scheduled to be phased in over a year, effective for each HHA at the commencement of its cost reporting year, the transition was subsequently accelerated such that all HHAs would be transferred by March 15. When plaintiffs now dealing with ODR were instructed to begin submitting their bills to the new intermediaries on March 1, they sought a temporary restraining order. On March 1, 1982 defendants were enjoined from requiring plaintiffs to submit their bills other than to ODR for a period of 10 days.

Prior to any decision on the merits, jurisdiction over the subject matter must be determined. Although it is undisputed

that jurisdiction lies regarding the claim under the APA, jurisdiction over the remaining matters is challenged by defendants.

Defendants claim that jurisdiction over all but the APA claims is precluded by section 205(h) of the Social Security Act, 42 U.S.C. § 405(h), incorporated into the Medicare Act by section 1872, 42 U.S.C. § 1395ii.¹ Section 405(h) provides:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decisions of the Secretary shall be reviewed by any person, tribunal or government agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under § 1331 and 1346 of title 28 to recover on any claim arising under this subchapter.

In *Weinberger v. Salfi*, 422 U.S. 749 (1975), a class action challenging the constitutionality of sections of the Social Security Act prohibiting a wage earner's widow or stepchild from receiving insurance benefits unless their relationships to the wage earner existed at least nine months prior to his death, the Supreme Court interpreted § 405(h) to bar federal question jurisdiction (under 28 U.S.C. § 1331). It rejected the district court's conclusion that § 405(h) amounted to no more than a codification of the doctrine of exhaustion of administrative remedies, and that exhaustion could be excused upon a judicial finding of futility. The third sentence of § 405(h), the Court stated, "is sweeping and direct and . . . states that *no* action shall be brought under § 1331, not merely that only those actions shall be brought in which administrative remedies have been exhausted." *Salfi*, at 757. The Court went on to decide that the claim arose under Title II of the Social Security Act

¹ The Medicare Act was enacted as amendment to the Social Security Act. It is Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* § 405(h) was originally applicable to Title II of the Social Security Act, which contains old-age, survivors, and disability insurance programs codified at 42 U.S.C. § 401 *et seq.*

(thereby barring federal question jurisdiction) and not under the Constitution, since it was Social Security benefits that plaintiffs sought to recover, and the Social Security Act provided both the standing and the substantive basis for the presentation of the constitutional contentions. However, jurisdiction under 42 U.S.C. § 405(g) of the Social Security Act, providing for district court review of the final decision of the Secretary after a hearing, was found over the claims of the named appellees, but not of the unnamed members of the class, for whom a final decision of the Secretary after a hearing was not alleged. Essentially the Court held that § 405(h) did not permit an alternative to § 405(g) jurisdiction, even where the administrative process mandated there could not resolve the constitutional question in issue.

The *Salfi* Court distinguished *Johnson v. Robison*, 415 U.S. 361 (1974), which found federal question jurisdiction over a constitutional attack on a statutory provision of the Veterans' Readjustment Benefits Act of 1966 despite a similar preclusion of review provision. In *Robinson*, there was no alternative avenue for review. Statutory preclusion of all review of a constitutional question would be "not only . . . extraordinary, such that 'clear and convincing' evidence would be required before we would ascribe such intent to Congress, but it would . . . [raise] a serious constitutional question of the validity of the statute so construed." *Salfi*, at 762. (Citations omitted). The scheme in the Social Security Act, on the other hand, was found not only constitutional but "manifestly reasonable," in that it "assures the Secretary the opportunity prior to constitutional litigation to ascertain, for example, that the particular claims involved are neither invalid for other reasons nor allowable under other provisions of the Social Security Act." *Id.*

Contrary to defendant's argument, the application of § 405(h) and *Salfi* to claims under the Medicare Act for which there is no alternative route to judicial review, as is the case here, is far from clear. As we have seen, the *Salfi* Court strongly suggested that it might have reached a different

result had there been no alternative basis for jurisdiction. The Courts of Appeals have come to varying conclusions when confronted with the issue. The First, Second, Fifth, Seventh and Eleventh Circuits have found that § 405(h) precludes judicial review over all Medicare cost reimbursement disputes, except as provided in the statute, save when they present constitutional claims. *Kechijian v. Califano*, 621 F.2d 1 (1st Cir. 1980); *Hospital San Jorge, Inc. v. United States Secretary of Health, Education and Welfare*, 598 F.2d 684 (1st Cir. 1979); *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910 (2d Cir. 1976); *Bussey v. Harris*, 611 F.2d 1001 (5th Cir. 1980); *Alabama Hospital Association v. Califano*, 587 F.2d 762 (5th Cir.), *cert. denied*, 444 U.S. 826 (1979); *Dr. John T. MacDonald Foundation, Inc. v. Mathews*, 554 F.2d 714 (5th Cir. 1977), *vacated*, *Dr. John T. MacDonald Foundation v. Califano*, 571 F.2d 328 (1978) (*en banc*), *cert. denied*, 439 U.S. 893 (1978); *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 570 F.2d 660 (7th Cir. 1977); *United States v. Sanet*, No. 81-5192 (11th Cir. decided February 1, 1982). Of these, the First Circuit has stated that jurisdiction under § 1331 might be available in the case of a colorable constitutional claim, *Kechijian*; *Hospital San Jorge*, and the Second Circuit, while generally referring such Medicare claims to the Court of Claims, e.g. *South Windsor*, in at least one case has assumed jurisdiction under § 1331, in part because no alternative remedy, including the Court of Claims, was available. *United States v. Aquevella*, 615 F.2d 12 (2d Cir. 1979).

The Fifth, Seventh, and Eleventh Circuits have not reached the question of whether § 1331 jurisdiction would ever be available in a Medicare case, because in the cases presented, jurisdiction was found in the Court of Claims. E.g. *Bussey*; *Trinity Memorial Hospital of Cudahy*; *Sanet*. (The instant case, in which declaratory and injunctive relief, rather than money damages, is sought, could not be brought in the Court of Claims, 28 U.S.C. § 1491, and neither could it be reframed as a claim for money damages. See *American Association of Coun-*

cils of Medical Staffs of Private Hospitals v. Califano, 575 F.2d 1367 (5th Cir. 1978)). The Ninth Circuit has held that § 1331 jurisdiction is generally unavailable, even over non-procedural constitutional claims, but also found jurisdiction in the Court of Claims, *Drennan v. Harris*, 606 F.2d 846 (9th Cir. 1979), and the Court of Claims has affirmed its own jurisdiction. *Whitecliff, Inc. v. United States*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

The District of Columbia, Eighth, and Ninth Circuits have held that purely procedural claims are not barred from federal question jurisdiction by § 405(h), because they are not actions "to recover on any claim" arising under the Medicare Act. *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir. 1976), *cert. denied sub nom. Faith Hospital Association v. Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976) (It appears from the language of this case that § 1331 jurisdiction might be found for all constitutional questions); *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473 (9th Cir. 1981).

The Sixth Circuit and the Court of Claims have found federal court jurisdiction more broadly available. In *Chelsea Community Hospital, SNF v. Michigan Blue Cross Association*, 630 F.2d 1131 (6th Cir. 1980), the Sixth Circuit ruled that § 1331 jurisdiction lies where no specific statutory avenue to judicial review is open. The Court of Claims has held that review is available where no administrative channels leading to review have been provided, at least so far as to ensure compliance with statutory and constitutional provisions. *Whitecliff*.

The Fourth Circuit has so far left open the question of jurisdiction over claims for which no alternative method of review is available, *Hopewell Nursing Home v. Bechtman*, No. 80-1846 (4th Cir., decided November 30, 1981), and our own Circuit, while implying agreement with courts holding that some avenue of review must be available where no administrative procedure is provided, *Humana* at 1076-77, has not

directly decided the issue. In *Humana*, some of the related claims were subject to administrative review, and the Court held that those procedures should be exhausted before court review of any of the claims. The district court there was ordered to retain jurisdiction over the claims not subject to administrative review, and decide, if necessary, its authority over those claims after administrative exhaustion concerning the other claims. *Id.* at 1085.

To draw at least one strand of agreement from this confusion, every court which has considered the issue, including the Supreme Court and our own Circuit Court of Appeals has stated, at least in *dicta*, that *some* avenue of judicial review must be available for constitutional claims. There is no hesitation in deciding that in this case, where review is not provided for in the Medicare Act and is not available in the Court of Claims, jurisdiction would lie in this court over constitutional claims. The more difficult question, and the one on which we must focus, is whether the plaintiffs' non-APA claims are in fact constitutional claims, and if not, should § 405(h) be interpreted in a manner which precludes review of statutory claims altogether.

Plaintiffs do not allege that they have a property interest in continuing to receive payments directly from the federal government. Rather, they assert a property interest in the unreimbursed expenses expected to be incurred due to the forced transition to designated intermediaries. (Plaintiffs' Opposition to Defendants' Motion for Summary Judgment and Plaintiffs' Motion for Summary Judgment at 51.) Accordingly, plaintiffs' claim of deprivation of property without just compensation in violation of the Fifth Amendment rests not on their claim of statutory entitlement to direct reimbursement or of statutory and procedural violations in the selection of intermediaries, but on a possible future uncompensated loss due to defendants' expected failure to reimburse what plaintiffs consider to be 100% of the costs attributable to the transition. If alleged, this claim, clearly speculative at this juncture, would be an attack on the Secretary's determination of "reasonable

costs" related to the transition, and not on the administrative instruction which is the subject of this case. Plaintiffs' asserted constitutional claim is in fact not part of this case. Their claimed rights to direct reimbursement, and to application of certain procedures in selecting intermediaries, do not have a constitutional basis. We are required to decide then whether § 405(h) bars nonconstitutional statutory claims in this case.

Although some courts have clearly held that only constitutional claims escape the jurisdictional bar of § 405(h), see pp. 5-6, *supra*, neither the Supreme Court nor the D.C. Circuit has reached this issue, and the Sixth Circuit and the Court of Claims have determined that federal jurisdiction is available over otherwise non-reviewable statutory claims. *Id.* Without binding precedent to guide us, we examine now both the rationale behind decisions holding that there is, or is not, jurisdiction, and any indications our own Circuit Court has given as to which way it would rule if faced with this issue.

Courts which have held review of Medicare claims to be precluded have relied primarily upon the Supreme Court's language in *Salfi* to the effect that § 405(h) is more than a codification of the doctrine of exhaustion of administrative remedies, and precludes all actions under § 1331, even claims embracing constitutional issues which cannot be reached in the administrative process. However, the context in which that language appeared in *Salfi* was in refutation of the district court's conclusion that exhaustion was not required because it appeared futile. The practical result in *Salfi* was to require administrative exhaustion, not to foreclose relief altogether. The doubts which the Supreme Court expressed as to the constitutionality of § 405(h) if interpreted to preclude all judicial review of constitutional questions have been echoed, as we have seen, by all the Circuit Courts which have encountered the issue under the Medicare Act, which unlike Title II of the Social Security Act, does not have an all-encompassing provision for administrative procedures leading to judicial review. Interpretations which avoid constitutional doubts have varied. Section 405(h) has been interpreted to preclude all review

under § 1331, but because by its terms it is not applicable to review in the Court of Claims, a forum for judicial review has been provided. Or, the phrase applying § 405(h) to the Medicare Act "as applicable" has been interpreted to mean that it does not apply to constitutional claims for which there is no other avenue of relief. Or, the particular cause of action is not seen as an action to "recover on any claim arising under the Act" because it does not seek to reverse the Secretary's decision concerning an actual claim for payment, but rather to attack the procedures employed in reaching a determination.

The same reasoning can apply to statutory claims. Although the language of *Salfi* referred to constitutional claims, the issue in that case being clearly of a constitutional nature, "the problem presented by a preclusion of review of a regulation for compliance with the authorizing statute is obviously quite similar." *Humana of South Carolina, Inc. v. Mathews*, 419 F. Supp. 253, 258 n.2 (D.D.C. 1976), *rev'd in part on other grounds sub nom. Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (1979). While the Circuit Court in *Humana* reversed in part the district court, holding that it should not have decided certain matters where related matters were subject to administrative review, it did not contradict the district court's statement that "[i]f . . . the Medicare Act does not provide . . . a mechanism [for review], nonstatutory judicial review continues to be available," *Humana*, 419 F. Supp. at 258, but rather left that question for later determination if necessary. *Humana*, 590 F.2d at 1085. In view of the general presumption in favor of judicial review of administrative action, see e.g. *Abbott Laboratories v. Gardner*, 387 U.S. 145 (1967), and the reasoning in the *Humana* cases, we conclude that § 405(h) should not be interpreted to preclude our jurisdiction over statutory claims under the Medicare Act where no alternative route to review is available. In addition to the total preclusion of review which could result, this case is also distinguished from *Salfi* and other cases which declined jurisdiction in not being a case "to recover on any claim" arising under the Medicare Act. Plaintiffs do not seek any type of eventual

monetary recovery on a reimbursement claim by this action. This case does not fit the language of § 405(h), nor the rationale of some courts which have denied review of provider reimbursement claims not previously subject to administrative review because they would "bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services . . . a matter peculiarly suited to determination by a specialized agency." *St. Louis University v. Blue Cross Hospital Service*. The issues in this case are purely legal, and perfectly suited to judicial resolution.

Accordingly, jurisdiction under 28 U.S.C. § 1331 lies for all of plaintiffs' claims in this action.

Plaintiffs assert that their right to be paid directly by the federal government stems from the original Medicare Act of 1965, at 42 U.S.C. § 1395g, stating:

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less than monthly) . . . the amounts so determined . . .

The Act also provides that when any group or association of providers of services "wishes" to have payments made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement whereby that entity determines the amount, and makes payments to providers. 42 U.S.C. § 1395(h).

Based on these statutory provisions, and language from the legislative history, plaintiffs argue that providers have a right to have the Secretary determine the amount to be paid and make payments, and the option, if they so choose, to have this function performed by an intermediary. There is no doubt but that both the House and Senate Reports on the 1965 Medicare Act demonstrate an understanding that providers had the

option of dealing directly with the Secretary. S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. and Admin. News 1993; H.R. Rep. No. 213, 89th Cong. 147-148 (1965). The legislative history to the 1977 amendments also reflects this view. H.R. Rep. 393, 95th Cong., 1st Sess. 68 (1977).

Defendants do not deny that this was the original understanding of Congress, and their own past practice.² They assert, however, that they always had the authority to reassign direct dealing HHAs to intermediaries pursuant to § 1395-*kk*, giving the Secretary the authority to perform his functions under the Act by contract. They also rely on the 1977 amendment to § 1395*h* of the Act which allows the Secretary to "assign or reassign any provider of services" to an intermediary if he determines, after applying certain standards, criteria and procedures, "that such designation would result in more effective and efficient administration" of the program, 42 U.S.C. § 1395*h*(e)(1)-(3); and on the 1980 amendment which states: "[T]he Secretary shall designate regional agencies or organizations which have entered into agreements with him under this section to perform such functions with respect to home health agencies . . . in the region." § 930(s)(1), Omnibus Reconciliation Act of 1980, P.L. 96-499, Title I, 94 Stat. 2599 (December 5, 1980), 42 U.S.C. § 1395(h)(e)(4).

Defendants argue that since the 1977 amendment gave the Secretary the authority to both assign and reassign providers to intermediaries, he had the authority to assign intermediaries to direct-dealing HHAs, i.e. to make initial assignments to intermediaries. However, neither the legislative history nor the Secretary's own past practice support this interpretation. The 1977 amendments are entitled the Medicare-Medicaid Antifraud and Abuse Amendments," and the House Commit-

² The Secretary's own regulations clearly state that providers may elect to receive payment "[d]irectly from the Administrator." 42 C.F.R. § 421.103 (1980).

tee Report makes clear that the purpose of the amendment in question was to authorize and require the Secretary to exercise more quality control over intermediaries, who were in a position of potential conflicts of interest in that their continued employment depended on the choice of the providers, and who had on occasion been found to be lax in performing their functions. The Secretary is permitted to override the provider's choice of intermediary, and required to develop standards, criteria and procedures to enable him to evaluate intermediaries' performance. H.R. Rep. No. 393, 95th Cong., 2d Sess. 68-70 (1977). None of this has any relevance to direct reimbursement. The Report states that the Secretary is not bound by a provider's choice in nominating an intermediary, *Id.* at 69, but never refers to providers who deal with ODR, or expresses any dissatisfaction with the quality of ODR's performance, or mandates any procedures to evaluate ODR's performance and compare it to that of intermediaries in order to make a decision on assignment or reassignment. It seems more probable that the reference to initial assignment in the statutory language refers to providers who have nominated an intermediary for the first time, and not to providers who are dealing with ODR and do not wish to nominate an intermediary. Either the defendants have themselves interpreted the language in this fashion until recently, or, at the very least, considered the wiser course of action to not disturb the choice of providers to deal with ODR. Their consistent policy until last year, as reflected in their own regulations, has been to afford providers an option to receive payment from ODR.

Defendants' interpretation of the 1977 amendment is also inconsistent with their position that § 1395-kk authorized them from the beginning to assign direct-dealing providers to intermediaries. The authority to assign providers to intermediaries not of their own choice given in the 1977 amendment was carefully circumscribed by requiring the Secretary to develop and utilize standards, criteria and procedures to determine whether the designation would result in more effective and efficient administration of the program, to furnish to the pro-

vider and the existing intermediary a full explanation of his reasons for that determination, and to afford the intermediary an opportunity for a hearing. 42 U.S.C. § 1395h(e)(1)-(3). An amendment which purportedly allows, under strictly defined procedures, the Secretary to do something he could always do anyway without those strictures defies reason. Either the 1977 amendment did not permit the reassignment of direct dealing HHAs, or the Secretary did not previously have the authority to do so under § 1395-kk.

As we have concluded, the 1977 amendment did not authorize the Secretary to reassign direct dealing HHAs. It remains to decide whether the 1980 amendment or § 1395-kk did so. The legislative history of the 1980 amendment is sparse. The House report reveals that the motive for the amendment was to standardize administrative and reimbursement practices of intermediaries, which were found to vary widely with respect to home health providers. In the words of the Committee,

[t]his is largely attributable to the small proportion of an intermediary's medicare business that is devoted to this particular type of provider. As a consequence, little expertise is developed in this area and there is no way of making meaningful comparisons of the utilization and cost of various agencies. Consolidation of the medicare home health business among a smaller number of intermediaries will enable intermediaries to focus more resources on the administration of the benefit and develop uniform cost and performance criteria.

H.R. Rep. 1167, 96th Cong. 2d Sess. 368, *reprinted in* 1980 U.S. Code Cong. and Admin. News 5732. Nowhere is direct reimbursement mentioned, and the concerns expressed clearly do not apply to ODR, which currently serves approximately 469 HHAs. (Defendants' Statement of Material Facts Not in Dispute ¶ 4.) The only reference to ODR is the statement of the Conference Committee to the effect that:

In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration.

House Conference Report No. 1479, 96th Cong., 2d Sess. (1980). (ODR is under the umbrella of the Health Care Financing Administration (HCFA)).

Section § 1395h(e)(4), contrary to defendants' contention, does not so unambiguously require the Secretary to assign *all* HHAs, including those now dealing with ODR, to regional intermediaries as to justify overlooking such undeniably clear statements in the legislative history. The language of the amendment, (see p. 12, *supra*) does not refer to *all* HHAs. The ambiguity is clarified by consistent indications in the legislative history as well as the administrative practice over the past 15 years, which lead incontrovertibly to the conclusion that not only did the 1980 amendment not *require* the Secretary to assign direct-dealing HHAs to regional intermediaries,³ but it also did not authorize him to do so. The language of the Conference Report unmistakably gives the election to the HHAs, who are not "precluded from contracting directly" with ODR.

In the face of continuing expressions of Congressional understanding that Medicare providers have the option to receive payment from the government directly, and the consistent 15 year practice on the part of the Secretary, defendants' argument that they always had the authority, under § 1395-kk, to contract out all of the services performed by ODR rings hollow. Defendants cannot point to any specific congressional expression of this interpretation, nor any indication that they themselves made this interpretation before 1980. See *Pltfs.' Ex. 32*. In 1966, defendants requested a legal opinion from their Office of General Counsel, as to whether the Secre-

³ Although defendants have contended in their pleadings that they are required by the 1980 amendment to reassign direct-dealing HHAs, defendants' own General Counsel in a memorandum dated January 11, 1982, stated in reference to the 1980 Conference Report, "... the better reading of this language is that it merely indicated that the Secretary is not required to assign a direct dealing home health agency to a regional intermediary." *Pltfs.' Ex. 36* at 5.

tary was "legally required to deal directly with providers electing to do so." The answer given by the Assistant General Counsel was that the Secretary did not have the right to designate an intermediary for a provider who did not elect to be served by an intermediary. Providers had the prerogative to have no intermediary. Certain ODR functions, for example, audit functions, however, could be performed by contract pursuant to § 1395-kk. Pltfs.' Ex. 33. While not an official declaration of agency policy, this statement, combined with the subsequent one and one-half decades' policy of allowing providers an election to deal with ODR, repromulgated in agency regulations as late as 1980, is strong evidence that the agency interpretation to which defendants now request the Court to afford deference is of recent vintage.

Under these circumstances, defendants' interpretation is not deserving of great deference, and we find, despite the general language of § 1395-kk appearing to permit the Secretary to contract out any of his functions under the Act, that he is not authorized to assign providers who have not elected to be so served to intermediaries. The more specific features of the statutory scheme, as we have seen, give providers who "wish" to do so the right to nominate an intermediary subject to the Secretary's approval, while retaining the option of dealing directly with the Secretary for others. The 1977 and 1980 amendments, while constricting the provider's right to select its own intermediary, were not intended to alter the status of direct-dealing providers. Congress has repeatedly expressed its understanding that providers have the option of dealing directly with the Secretary. Section 1395-kk cannot, suddenly, and contrary to Congressional understanding, be brought into service to allow defendants to abolish that option.

We express no opinion as to the desirability of requiring all home health agencies to deal with regional intermediaries, eliminating ODR's function in relation to them. Defendants are certainly free to attempt to persuade Congress to authorize such a policy. Congress may accept or reject that attempt. However, defendants may not implement this plan absent Congressional approval.

Having determined that defendants may not reassign direct dealing HHAs, plaintiffs' contention that the Secretary failed to apply the statutorily-mandated standards, criteria and procedures (42 U.S.C. § 1395h(f)) to the selection of the regional intermediaries remains relevant only to those HHAs who were previously served by intermediaries and are now required to transfer to the newly designated intermediaries. Although plaintiffs admit that the language of § 1395h(e)(4) (the 1980 amendment) excuses the Secretary from making a determination under the regulatory standards, criteria and procedures as to whether designating a regional intermediary will result in ". . . the more effective and efficient administration" of the Medicare program,⁴ plaintiffs nonetheless maintain that defendants are still bound by § 1395h(b) to apply the standards, criteria and procedures developed under § 1395h(f) to determine that the designation of the regional intermediaries is "consistent" with the effective and efficient administration of the program. However, § 1395h(b) applies by its terms to entering or renewing agreements with intermediaries, while the 1980 amendment requires the Secretary to designate regional intermediaries who already have agreements with the Secretary, (i.e., existing intermediaries). Accordingly, plaintiffs' claim under § 1395(b) fails. The Secretary has not violated this provision or its regulatory implementation in selecting the regional intermediaries for those HHAs who choose to be served by intermediaries.

⁴ § 1395(e)(4) provides that regional intermediaries shall be designated "[n]otwithstanding subsections (a) and (d) and paragraphs (1), (2) and (3) of this subsection," which include the provisions requiring a determination by the Secretary, using the mandated standards, criteria and procedures to determine that an assignment or reassignment to an intermediary would result in the more effective and efficient administration of the program, and requiring the Secretary to provide an explanation of his determination to the provider and the existing intermediary and to afford the intermediary a hearing. 42 U.S.C. § 1395h(e) (1), (2) and (3).

Plaintiffs' final contention is that defendants failed to follow the procedures mandated by the APA for rulemaking in promulgating their policy. Again, as defendants may not reassign direct-dealing HHAs at all under the current statutory scheme, this claim only has relevance to HHAs previously dealing with intermediaries. There is no dispute but that defendants were required by the 1980 Amendment to designate regional intermediaries for HHAs who choose to deal with intermediaries. The regional intermediaries were selected from among existing intermediaries, thus some HHAs remained with the same intermediaries, while others have been or will be transferred. Some members of plaintiff National Association of Home Health Agencies are in the latter category. Plaintiffs allege that this group (along with those transferring from ODR) is seriously affected by the timing of the transition and by the designation of particular intermediaries, in that the speed of the transition and the lack of capacity of some of the designated intermediaries have already or may later result in delays in payment and other inefficiencies. According to affidavits submitted by some of the plaintiffs, these conditions impact the plaintiffs economically, and could result in forcing them to reduce staff, eliminate services, or go out of business entirely. Pltfs.' Exs. 14 at 3, 21, 23, 24, 28, and 40. They contend that the administrative instruction here fits the APA definition of a "rule,"⁵ and is a "substantive rule" subject to the notice and comment procedures of 5 U.S.C. § 553 because it has a substantial impact upon them. See *Brown Express, Inc. v. United States*, 607 F.2d 695 (5th Cir. 1979).

⁵ "[R]ule means the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing" 5 U.S.C. § 551(4).

Defendants, while not claiming to have followed the APA procedures of Federal Register notice of proposed rules, opportunity for interested persons to comment, consideration of the comments, and publication of the final rules with a concise general statement of their basis and purpose 30 days before their effective date, contend that the December 1981 instruction is not a rule, and that even if it were it would be exempt from notice and comment procedures. It is not a rule, they assert, because they have a mandatory duty to designate intermediaries, and there are no policy options on which to comment. The Secretary has not engaged in rulemaking, but has acted to carry out a nondiscretionary duty. This statement does not withstand scrutiny. As plaintiffs have pointed out, defendants were given the discretion to delineate the regions (they chose statewide regions), select the regional intermediaries from among existing intermediaries, and schedule the implementation of the transition. Defendants also perceived policy options in their implementation of the assignment of regional intermediaries. In their September 1980 intermediary letter,⁶ opinions and recommendations were sought from intermediaries as to what defendants considered "major issues" relevant to the proposed policy. "1. Should there be any exceptions to the proposal for one intermediary per State? . . . 2. Should there be a separate treatment for multi-provider chains? . . . 3. Should the Office of Direct Reimbursement be available for servicing local Government operated home health agencies? . . . 4. What is the most effective way for making the transition to a Statewide intermediary?" Exhibit A to the January 12, 1982 Affidavit of Tera S. Younger. Any number of

⁶This letter is dated prior to the enactment of the 1980 amendment. Defendants were then considering the designation of regional intermediaries pursuant to their purported authority under the 1977 amendment. The 1980 amendment, although requiring the Secretary to implement the option of designating regional intermediaries, did not circumscribe the Secretary's discretion in the areas discussed in the letter.

policy issues could have been subject to comment. For example, plaintiffs' concern that Medicare will not fully compensate the cost of the transition could have been formally examined and addressed before the transition began. (Plaintiffs were obviously uncertain about Medicare's policy on this matter at the commencement of this lawsuit). Doubts related to the regional intermediaries' ability to timely process claims during the transition and the HHAs' resulting cashflow problems could have been addressed. Plaintiffs as affected parties undoubtedly had opinions as to the most effective, and least costly way to accomplish the transition. This is not to say that some input on these issues was not received and considered by defendants. But it was not done in accordance with APA procedures.

The December, 1981 instruction is an agency statement of general applicability and future effect designed to implement law, and therefore a rule under the APA. It is not an interpretive or procedural rule excepted from notice and comment requirements. It is a substantive rule because it substantially impacts the rights and obligations of affected parties. *Chrysler Corp. v. Brown*, 441 U.S. 281, 301-302 (1979); *Batterton v. Marshall*, 648 F.2d 694 (D.C. Cir. 1980).

Defendants next argue that notice and comment procedures were not required in this case because plaintiffs, as demonstrated by their own exhibits (Pltfs.' Ex. 7, 12, and 27) had actual notice of the policy throughout the course of its development, and did submit comments. However, the fact that some plaintiffs had learned of the proposed policy and submitted unsolicited comments does not prove that all of the plaintiffs had actual notice, or that the notice they had adequately described the proposed rule for APA purposes.

In fact, defendants impermissibly relied on word of mouth and third parties to afford plaintiffs notice. The August 1980 intermediary letter proposing the policy was circulated to intermediaries and HCFA components, not HHAs, for comment. January 12, 1982 Affidavit of Tera S. Younger at ¶ 6.

Defendants subsequently did meet with plaintiff National Association of Home Health Agencies (NAHHA) to discuss the proposal and request its help in soliciting individual HHA comments. *Id.* News of the proposed policy appeared in NAHHA's August, 1980 Newsletter, and defendants did receive comments from HHAs on the proposed policy. However, there was no guarantee, and there is no proof now, that all affected HHAs received actual notice. In fact, some representatives of HHAs have averred in affidavits in this case that they did not receive notice. Pltfs.' Ex. 16, 19, 29. Constructive notice through national associations and trade journals is not adequate. The Federal Register is the only acceptable form of constructive notice under the APA. *Rodway v. United States Department of Agriculture*, 514 F.2d 809, 815 (D.C. Cir. 1975). In any case, the August, 1980 letter did not contain a fully-formulated proposal.

In August of 1981, HCFA provided a more detailed account of its policy to national HHA associations, and to intermediaries, who were asked to forward copies to the HHAs they served. Younger affidavit at ¶ 9 and Exhibit E to the affidavit. Again, a request to a third party to provide notice does not meet the requirement of actual notice. Furthermore, this letter announced an already formulated policy, not a proposed policy concerning which comments would be considered. The December 1981 instruction, which also only reached HHAs by way of their intermediaries, merely described the action taken, and solicited no comments.

Whether or not defendants were excused from publication of the proposed rule in the Federal Register, they were still obligated to consider the comments and publish a final rule with a concise general statement of its basis and purpose 30 days before its effective date. Although defendants claim to have considered the comments received, they did not formally address them and provide the statement of basis and propose required in the Federal Register.

Defendants must address the discretionary aspects of the transition to regional intermediaries in a proposed rule, pub-

lished in the Federal Register, solicit comments, consider the comments, and publish the final rule with the required statement.

Although it is regrettable that the transition process must be interrupted in mid-course, we have no choice but to require compliance with the law.

An appropriate judgment accompanies this Memorandum Opinion.

/s/ JOYCE HENS GREEN
Joyce Hens Green
United States District Judge

March 10, 1982

United States District Court

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 81-3160

NATIONAL ASSOCIATION OF HOME
HEALTH AGENCIES, *et al. Plaintiffs,*

v.

RICHARD S. SCHWEIKER, *et al., Defendants.*

FILED

March 10, 1982

JAMES F. DAVEY, Clerk

JUDGMENT

It is this 10th day of March, 1982, hereby

ORDERED, that declaratory judgment is entered in favor of plaintiffs National Association of Home Health Agencies; Home Health Services and Staffing Association; Upjohn Healthcare Services, Inc.; Alabama Department of Public Health; Barber County Community Home Health Agency; Chataugua County Home Health Agency; Comprehensive Home Health Services; Elk County Home Health Agency; Franklin County Nursing Service; Golden Belt Home Health Services; Harvey County Home Health Agency; Home Health Services of Lake County; Home Health Services of Tarrant County, Inc.; Hub City Home Health Services, Inc.; Kiowa Comanche Home Health Agency; Koochiching County Nursing Service; Lake of the Woods Nursing Service; Lincoln, Lyon, Murray & Pipestone Community Health Services; Medical Home Care Services; Mediserv Home Health Agency; Mid-Peninsula Health Services, Inc.; Mitchell County Home Health Agency; Mountain and Valley In-Home Services, Inc.; Nassau County Department of Health; Pottawatomie City Home Health Agency; Roseau County Nursing Service; San

Diego Hospice Corporation; San Francisco Home Health Services; Santa Barbara Visiting Nurse Association; South Mississippi Home Health & Rehabilitation Agency, Inc.; Trend Home Health Agency; Trico Home Health Services, Inc.; Tri-County Home Health Care; Visiting Nurse Association of Alameda County; Visting Nurses Association of Greater Chesterfield; Visiting Nurse Association of Northern Virginia; VNA of San Diego; VNA of San Francisco; VNA of Southwest Louisiana, Inc.; VNA of Ware County; and VNS of Verdugo Hills, and against defendants Richard S. Schweiker, Secretary, United States Department of Health and Human Services andCarolyn K. Davis, Administrator of the Health Care Financing Administration, United States Department of Health and Human Services, to the effect that defendants' December 8, 1981 instruction to intermediaries violates the Medicare Act insofar as it assigns plaintiffs who choose to deal with defendants' Office of Direct Reimbursement to regional intermediaries for the purpose of Medicare reimbursement determinations and payment, and it is

FURTHER ORDERED, that defendants are permanently enjoined, absent new statutory authorization, from requiring plaintiffs, absent their election to do so, to seek Medicare reimbursement determinations and payment from other than defendants' Office of Direct Reimbursement, and it is

FURTHER ORDERED, that judgment is entered in favor of defendants Richard S. Schweiker, Secretary, United States Department of Health and Human Services and Carolyn K. Davis, Administrator of the Health Care Financing Administration, United States Department of Health and Human Services and against plaintiffs National Association of Home Health Agencies; Home Health Services and Staffing Association; Upjohn Healthcare Services, Inc.; Alabama Department of Public Health; Barber County Community Home Health Agency; Chataugua County Home Health Agency; Comprehensive Home Health Services; Elk County Home Health Agency; Franklin County Nursing Service; Golden Belt Home Health Services; Harvey County Home Health

Agency; Home Health Services of Lake County; Home Health Services of Tarrant County, Inc.; Hub City Home Health Services, Inc.; Kiowa Comanche Home Health Agency; Koochiching County Nursing Service; Lake of the Woods Nursing Service; Lincoln, Lyon, Murray & Pipestone Community Health Services; Medical Home Care Services; Mediserv Home Health Agency; Mid-Peninsula Health Services, Inc.; Mitchell County Home Health Agency; Mountain and Valley In-Home Services, Inc.; Nassau County Department of Health; Pottawatomie City Home Health Agency; Roseau County Nursing Service; San Diego Hospice Corporation; San Francisco Home Health Services; Santa Barbara Visiting Nurse Association; South Mississippi Home Health & Rehabilitation Agency, Inc.; Trend Home Health Agency; Trico Home Health Services, Inc.; Tri-County Home Health Care; Visiting Nurse Association of Alameda County; Visiting Nurses Association of Greater Chesterfield; Visiting Nurse Association of Northern Virginia; VNA of San Diego; VNA of San Francisco; VNA of Southwest Louisiana, Inc.; VNA of Ware County; and VNS of Verdugo Hills, on plaintiffs' claim that the Secretary failed to comply with 28 U.S.C. § 1395(b) in the designation of regional intermediaries, and it is

FURTHER ORDERED, that judgment is entered in favor of plaintiffs National Association of Home Health Agencies; Home Health Services and Staffing Association; Upjohn Healthcare Services, Inc.; Alabama Department of Public Health; Barber County Community Home Health Agency; Chataqua County Home Health Agency; Comprehensive Home Health Services; Elk County Home Health Agency; Franklin County Nursing Service; Golden Belt Home Health Services; Harvey County Home Health Agency; Home Health Services of Lake County; Home Health Services of Tarrant County, Inc.; Hub City Home Health Services, Inc.; Kiowa Comanche Home Health Agency; Koochiching County Nursing Service; Lake of the Woods Nursing Service; Lincoln, Lyon, Murray & Pipestone Community Health Services; Medical Home Care Services; Mediserv Home Health Agency; Mid-Peninsula Health

Services, Inc.; Mitchell County Home Health Agency; Mountain and Valley In-Home Services, Inc.; Nassau County Department of Health; Pottawatomie City Home Health Agency; Roseau County Nursing Service; San Diego Hospice Corporation; San Francisco Home Health Services; Santa Barbara Visiting Nurse Association; South Mississippi Home Health & Rehabilitation Agency, Inc.; Trend Home Health Agency; Trico Home Health Services, Inc.; Tri-County Home Health Care; Visiting Nurse Association of Alameda County; Visiting Nurses Association of Greater Chesterfield; Visiting Nurse Association of Northern Virginia; VNA of San Diego; VNA of San Francisco; VNA of Southwest Louisiana, Inc.; VNA of Ware County; and VNS of Verdugo Hills, and against defendants Richard S. Schweiker, Secretary, United States Department of Health and Human Services and Carolyne K. Davis, Administrator of the Health Care Financing Administration, United States Department of Health and Human Services on plaintiffs' claim that defendants' promulgation of the policy requiring Home Health agencies to be served by designated regional intermediaries is subject to the notice and comment procedures mandated at 5 U.S.C. § 553, and it is

FURTHER ORDERED, that within 30 days of this date, defendants shall publish in the *Federal Register* a proposed rule, in accordance with the Memorandum Opinion of this date, and solicit comments thereon from interested parties. Until the procedures mandated in 5 U.S.C. § 553 are completed, Home Health Agencies shall have the option of obtaining Medicare cost reimbursement determinations and payment from the organizations or agencies which served as their intermediaries prior to the designation of regional intermediaries.

/s/ JOYCE HENS GREEN
 Joyce Hens Green
 United States District Judge

APPENDIX D
United States District Court

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 81-3160

NATIONAL ASSOCIATION OF HOME
HEALTH AGENCIES, *et al.* *Plaintiffs*,

v.

RICHARD S. SCHWEIKER, *et al.*, *Defendants*.

FILED
March 1, 1982

JAMES F. DAVEY, Clerk

TEMPORARY RESTRAINING ORDER

This matter, having come before this Court upon the complaint filed by plaintiffs, plaintiffs' motion for a temporary restraining order pursuant to Rule 65(b) of the Federal Rules of Civil Procedure, plaintiffs' memorandum in support of that motion, the written declaration submitted by the defendants, and oral argument by both parties, for the reasons stated orally on the record this date, it is this 1st day of March, 1982, hereby

ORDERED, that defendants and their officers, agents, servants, employees, attorneys, and those persons in active concert with them shall not, for a period of 10 days or until this Court can render a final determination in this action if sooner, require plaintiffs to submit requests for Medicare reimbursement to other than the defendants' Office of Direct Reimbursement; and said Office shall continue to process those claims in the usual manner during that time period.

This Order is issued at 2:22 p.m. March 1, 1982 and shall expire, unless extended, at 2:22 p.m. March 10, 1982.

Security will be required of the plaintiffs in the amount of \$100.00 cash or surety.

/s/ JOYCE HENS GREEN
Joyce Hens Green
U. S. District Judge

APPENDIX E

42 U.S.C. § 1395g. Payments to providers of services; conditions; amount; payments under assignment or power of attorney

(a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments;

...

42 U.S.C. § 1395h. Use of public or private agencies or organizations to facilitate payment to providers of services—Authorization for agreement by Secretary for implementation; scope of agreement

(a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1395oo of this title and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e) of this section), and for the making of such payments by such agency or organization to such providers (and to providers assigned to such agency or organization under subsection (e) of this section).

...

42 U.S.C. § 1395kk. Administration

(a) Except as otherwise provided in this subchapter and in the Railroad Retirement Act of 1974, the insurance programs established by this subchapter shall be administered by the Secretary. The Secretary may perform any of his functions under this subchapter directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

APPENDIX F

42 C.F.R. § 421.103 Option available to providers.

A provider may elect to receive payment for covered services furnished to Medicare beneficiaries:

(a) Directly from the Administrator;

or

(b) Through an intermediary, when both the Administrator and the intermediary consent.

42 C.F.R. § 421.104 Nominations for Intermediary.

(b) Nomination by nonmembers or nonconcurring members. Providers that nonconcur in their association's nomination, or are not members of an association, may:

(1) Form a group of 2 or more providers for the specific purpose of nominating an intermediary, in accordance with provisions of paragraph (a) of this section; or

(2) Exercise their right to receive payment directly from the Administrator in accordance with § 421.103.

33 Fed. Reg. 11277-78 (August 8, 1968)

20 C.F.R. § 405.651 Nomination of agency or organization as "intermediary": contractual undertakings with intermediaries.

(a) Under section 1816 of the Act, groups of providers or associations of providers, may nominate on behalf of the members of such group of association, a national, State, or other public or private agency or organization for the purpose of entering into an agreement with the Secretary providing for the determination of amounts payable under title XVIII, and the making of such payments, by such agency or organization to providers of services. A member of a group or association may, however, deal directly with the Secretary rather than through an intermediary. The nomination of an agency or

organization by a group or association of providers of services (see § 405.653); shall not be binding on any member of such group or association if such member notifies the Secretary of its desire not to be bound by such nomination.

20 C.F.R. § 405.654 Election to deal through a nominated agency or organization or to deal directly with the Secretary.

A provider which is not a member of a group or association which has nominated an intermediary or a nonconcurring member of a group or association of providers of services, may with the consent of the Secretary and an agency or organization which has entered into an agreement with the Secretary, elect such agency or organization to determine the amount of and make payment to such provider under the provisions, described in Subpart A of this part or, elect to receive payment directly from the Secretary. This procedure is also available to any provider of services which has forwarded notice of intent to withdraw its concurrence in the nomination or its election of a particular agency or organization (see § 405.656).

APPENDIX G

medicare

Part A Intermediary Letter

Department of Health
and Human Services

Health Care Financing
Administration

Transmittal No. A-81-32

Date December 1981
BPO-P13

**SUBJECT: Designation of Regional Intermediaries to Serve
Freestanding Home Health Agencies—
ACTION**

Intermediaries have now been selected to serve freestanding home health agencies (HHAs) as required by the Omnibus Reconciliation Act of 1980. As you recall, I.L. A-81-21 transmitted a briefing paper which outlined the Health Care Financing Administration's (HCFA) final plan for implementing this legislation.

Attachment 1 identifies designated intermediaries for each State and discusses some implementation issues. Please forward one copy of this paper to each of the HHAs you now serve (both freestanding and provider-based) using the draft language in Attachment 2 as appropriate.

Attachment 3 provides guidelines on change of intermediary activities connected with the implementation of HHA intermediaries. Your HCFA Regional Offices will contact you to set up a meeting with affected HHAs and intermediaries to go over these plans.

Questions concerning this letter should be referred to your servicing HCFA regional office.

3 Attachments

Designation Of Regional Medicare Intermediaries To Serve Freestanding Home Health Agencies

The Health Care Financing Administration (HCFA) has now selected intermediaries to serve freestanding home health agencies (HHAs) as required by the Omnibus Reconciliation Act of 1980. Exhibit 1 lists the organizations which have been designated for each State.

BACKGROUND

P.L. 96-499 directed the Department of Health and Human Services (DHHS) to designate regional intermediaries to serve freestanding HHAs. This legislation was an outgrowth of concern about fraud and abuse resulting in overpayments to HHAs, as well as more general interest in improving contractual arrangements with the private sector for administering the Medicare program. The purpose of the legislative provision was to assure that each intermediary would have a sufficient number of HHAs to develop expertise in claims adjudication and audit activities and give sufficient priority attention to their HHA workload.

In August of 1981, HCFA notified home health agencies, intermediaries, and other interested parties of its plans to designate one intermediary to serve freestanding HHAs in each state. After announcement of its plans for implementing this legislation, HCFA used a structured process to select an HHA intermediary for each State. Selection criteria included past performance, current volume of HHA workload, and ability to assume the additional workload. Input solicited from HHAs was considered in those States where a more than one intermediary currently serves a significant volume of HHAs.

IMPACT

We believe the designation of the regional HHA intermediaries listed in Exhibit 1 will achieve the goal of both Congress and HCFA to improve the administration of the home health benefit under the Medicare program. Consolidating the workload of freestanding HHAs under a single intermediary in each

State should improve management and control of coverage and reimbursement determinations for HHAs. The use of State intermediaries will also facilitate intermediary onsite review of HHAs which has proven to be a significant tool for assuring improved reimbursement determinations and controlling overutilization and overpayments which have been of concern to HCFA and the Congress in the past. Consistent application of Medicare policies with respect to HHAs within each State will enhance delivery of necessary services by providing predictability for providers, beneficiaries and the health care community.

Approximately 29 percent of HHAs participating in the Medicare program will be reassigned to another intermediary as a result of implementation of this legislation. The number of intermediaries serving freestanding HHAs will be reduced from 72 to 49 as a result of this action. Freestanding HHAs in 17 States are already served by the designated organization, thus no reassignments will occur in these States. (No HHA intermediary will be designated for Puerto Rico and the Virgin Islands because of the proposed competitive procurement to select a single organization to serve their entire Medicare workload.) In many additional States, only a minimal number of agencies will be affected since the designated intermediary already serves the majority of HHAs in the State. In only 12 States will there be a major shift of HHAs to a new intermediary (Alabama, Arizona, Arkansas, California, Florida, Ohio, Pennsylvania, South Carolina, Texas, Virginia, Washington, West Virginia). The following implementation procedures are designed to assure a smooth transition to the new intermediaries.

IMPLEMENTATION

HCFA will work closely with intermediaries and HHAs throughout the implementation process to assure a smooth transition and no interruption in cash flow. In the States with a significant volume of HHA transfers, committees consisting of HCFA RO, intermediary and State HHA association repre-

sentatives will be established to coordinate transition activities. In other affected States, ROs will keep in touch with intermediaries and reassigned providers to discuss implementation issues.

Freestanding HHAs not currently dealing with the designated intermediary in their State will be transferred to that organization beginning on January 1, 1982, based on provider cost reporting year ending dates. (For example, a freestanding HHA with an accounting year ending December 31, 1981, will be transferred to the new intermediary on January 1, 1982.) Our data indicates that the majority of HHA reassignments will occur on January 1, 1982 (38 percent), July 1, 1982 (31 percent), and October 1, 1982 (15 percent).

The designated intermediary will assume responsibility for bill processing on the effective date of the transfer, as well as audit and cost report settlement of the cost report which begins on that date. The current intermediary will continue to be responsible for auditing and settling the cost report for the period ended just before the transfer. The transition committee will assure that there is no interruption in cash flow to providers. PIP rates and reimbursement rates will be continued "as is" for the initial cutover period until the designated intermediary becomes familiar with new HHAs' accounting systems. HCFA ROs will closely monitor transition activities and operation of designated intermediaries to assure the establishment of effective intermediary/HHA relationships.

Because of the short time before implementation, the transfer of bill processing for HHAs reassigned effective January 1, 1982, may be delayed if deemed necessary by the transition committee to promote a smooth transfer. However, responsibility for cost report settlement would still be transferred effective January 1, 1982.

The transfer of HHAs billing the Office of Direct Reimbursement on an automated basis will be timed on an individual basis to assure that the designated State intermediary can handle the HHAs' billing needs. Designated intermediaries will be

asked to contact any automated billing HHAs in their service area to work on a mutually agreeable billing system (whether telecommunications or magnetic tape) which meets HCFA's data requirements. This flexibility should be able to serve the needs of both HHAs and HCFA.

HCFA will evaluate requests from multi-State HHA chains to have all their audit and settlement work done by a single intermediary on a case-by-case basis. Approval will be based on whether the degree of centralization of the chain organization would make such a deviation efficient and effective.

PROBLEM RESOLUTION PROCEDURE FOR HHAS

We believe that the vast majority of reassigned HHAs will be able to establish good working relationships with designated intermediaries. However, we recognize that there may be a limited number of cases in which a given HHA has a problem which they are unable to resolve with their designated intermediary. HCFA ROs will investigate such cases and resolve problems. Such problems and their resolution will be used to evaluate intermediary performance and make decisions about continuing designations.

APPENDIX H

Parties To This Proceeding And Their Member Organizations And Parent Companies

National Association of Home Health Agencies	Hub City Home Health Services, Inc.
Home Health Services and Staffing Association	Kiowa Comanche Home Health Agency
Upjohn Healthcare Services	Koochiching County Nursing Service
The Upjohn Company	Lake of the Woods Nursing Service
Alabama Department of Public Health	Lincoln, Lyon, Murray, & Pipestone Community Health Services
Barber County Community Home Health Agency	Medical Home Care Services
Chataugua County Home Health Agency	Mediserv Home Health Agency
Comprehensive Home Health Services	Mid-Peninsula Health Services, Inc.
Elk County Home Health Agency	Mitchell County Home Health Agency
Franklin County Nursing Service	Mountain and Valley In-Home Services, Inc.
Golden Belt Home Health Services	Nassau County Department of Health
Harvey County Home Health Agency	Pottawatomie City Home Health Agency
Home Health Services of Lake County	Roseau County Nursing Service
Home Health Services of Tarrant County, Inc.	

San Diego Hospice
Corporation

San Francisco Home Health
Services

Santa Barbara Visiting
Nurse Association

South Mississippi Home
Health & Rehabilitation
Agency, Inc.

Trend Home Health Agency

Trico Home Health
Services, Inc.

Tri-County Home Health
Care

Visiting Nurse Association
of Alameda County

Visiting Nurses Association
of Greater Chesterfield

Visiting Nurse Association
of Northern Virginia

VNA of San Diego

VNA of San Francisco

VNA of Southwest
Louisiana, Inc.

VNA of Ware County

VNS of Verdugo Hills

Visiting Nurse Association
of Springfield, MA

International Homemakers

Community Nurse
Association

District Nursing Association

Westport Home Health
Agency

Lakes Region Community
Health

Androscoggin Home Health
Service

Salisbury Public Health
Nursing

Family Services - Woodfield

St. Luke's Home Care
Program

Condado Home Care
Program, Inc.

Hospital Sin Paredes, Inc.

Bayonne Visiting Nurse
Ass'n.

Patient Care Medical
Services

MCOS Nursing Services,
Inc.

Gloucester County Visiting
Nursing Association, Inc.

Visiting Nurse Service of
New York

Long Island College
Hospital

The Brooklyn Hospital

The Methodist Hospital
Home Care

Visiting Nurse Association
of Brooklyn

Maimonides Medical Center
Metropolitan Jewish
Geriatric

Jewish Hospital and Medical
Center Home Health
Agency

Visiting Homemaker
Services

Visiting Nurse Association
of Buffalo

Visiting Nurse Association
of Rochester & Monroe
Counties

South Hills Health Systems
Northwest Allegheny Home
Health Care Agency

Butler Home Health Care
Agency of Erie County

North Penn Home Health
Agency

Visiting Nurse Association of
Carlisle Hospital

Visiting Nurse Association
of Mechanicsburg, PA

Home Care Services Agency

Visiting Nurse Association
of Hanover, PA

Visiting Nurse Association
of Spring Grove, PA

Columbia Montour Home
Health Service

Home Health Care of Beth-
lehem, PA

Visiting Nurse Association
of Bethlehem, PA

Chester Medical Center
Holy Redeemer Visiting
Nurse Association

Adventist Home Health
Service

Holy Cross Hospital Home
Health Care Service

Staff Builders Home Health
Care

West Baltimore Community
Health Care Corporation

Good Samaritan Hospital
HomeCall, Inc.

Bur Home Health Services

Department of Nursing, Old
Dominion University

Maryview Hospital

Toledo District Nurse Ass'n.

Deaconess Home Health
Agency

Visiting Nurse Service, Inc.

Carroll County Visiting Nurse Association	We Care Nursing Service
Cinciannati Health Dept.	Outreach Home Health Service
Visiting Nurse Association of Dayton, OH	Grant County Nurses
United Health Program - Calumet Huntington County Home Health Agency	Green Bay Visiting Nurse Association
Visiting Nurse Association of Southwest Indiana	Wausau Visiting Nurse Association
Visiting Nurse Association of St. Clair County	Community Health & Social Services
Monroe County Health Dept.	Metro Home Health Care, Inc.
Michigan Cancer Foundation Svc.	Ebenezer Society
Visiting Nurse Association of Metropolitan Detroit	North Memorial Medical Center
Lapeer County Health Dept.	Dept. of Community Services
Central Michigan District of Health	Alexian Brothers Medical Center
Shiawassee County Health Dept.	Lake Forest Hospital Home Care
In-Home Health Care Service	In Home Health Care Service of Suburban Chicago North, I
St. Joseph District of Health	In Home Health Care Service of Suburban Chicago West
Jackson County Health Dept.	Country Care, Inc.
Trinity Memorial Hospital	Home Health Service
	United Homecare, Ltd.

Bodimetric Health Services, Inc.	Home Health Care Agency, Inc.
Chicago Center Memorial Hospital	Valley View Hospital
Rogers Park Home Health Care	Visiting Nurse Associaton of Dallas
Visiting Nurses Association of Rockford, IL	Red River Valley Home Health Agency
Rock Island County Health Dept.	Mobile Nurses, Inc.
Peoria City/County Health Dept.	East Texas Home Health Agency
Home Health Services of Mercy	Home Health-Home Care, Inc.
Lincolnland Visiting Nurse Ass'n.	North Central Texas Home Health Agency, Inc.
St. Francis Hospital	Wichita Home Health Service
Visting Nurse Association of St. Clair County	West Texas Home Health Agency
Home Health Service of St. Joseph's Hospital	Home Health Agency of Texas, Inc.
Lawrence County Health Dept.	Waco-McLennan County Health Center
Good Samaritan Hospital	Nurses PRN, Inc.
Tip of Illinois Health Svc.	Visiting Nurse Association of Houston
Metropolitan Health Services	Logos Nursing Personnel Service
Lee County Cooperative Clinic	Visiting Nurse Association of Montgomery County, TX
CMH Home Health Agency	

Home Health-Home Care,
Inc.

Visiting Nurse Association
of Brazoria County, TX

Home Health-Home Care,
Inc.

Upjohn Health Care
Services, Inc.

Home Health-Home Care,
Inc.

Port Arthur Home Health
Service

Texas Home Health, Inc.

Upjohn Health Care
Services, Inc. of Beaumont,
TX

Beaumont Home Health
Service

Home Health-Home Care,
Inc. of Brenham, TX

Victoria Home Health
Agency

Hill Country Home Health
Agency

Home Health-Home Care,
Inc. of San Antonio, TX

Valley Home Health Agency

Homemakers East Texas -
DBA Upjohn Healthcare

Girling Health Care, Inc.

West Texas Home Health
Agency

Good Samaritan Health
Care, Inc.

West Central Texas Home
Health

Hospital Home Health Care

Albuquerque Visiting Nurse
Service

Ames Visiting Nurse
Service

Cass County Memorial
Hospital

Dubuque Visiting Nurse
Ass'n.

Community and Home
Health Services Agency

Public Health Nursing
Ass'n.

Visiting Nurse and
Homemaker Service

Home Care Program of
Greater St. Louis

Visiting Nurse Association
of Greater St. Louis

Northeast Missouri Home
Health Agency

Independence Home Health
Agency

John Knox Home Health
Agency

Spelman Memorial Hospital	Home Health Agency of Catholic
Johnson County Community Health Service	VNA of Kansas & Wyandotte Counties
Catholic Charities of Kansas City	Topeka-Shawnee County Health Department
Methodist Care Center Home Care	Harper County Home Health Agency
Visiting Nurse Association of Greater Kansas City	Susan B. Allen Memorial Hospital
St. Francis Hospital Home Health Agency	Harvey County Home Health Agency
Sac Osage Home Health Agency	Dept. of Community Health
Nevada City Hospital Home Health Agency	Trinity Home Health Agency
St. John's Medical Center	Burt-Washington Home Health Care
McDonald County Home Health Agency	Home Health Agency of Omaha
Missouri River Home Health Agency	Lutheran Medical Center
Columbia Visiting Nurse Association	Archbishop Bergen Mercy Hospital
Meramec Home Health Agency	State Health Department (NE)
Lake Ozard Area Home Health Agency	Tabitha Home Health Care
Riverways Home Health Agency	St. Francis Home Health
Visiting Nurse Association	Good Samaritan Hospital
OACAC	Home Health Agency of Mary Lan

Phelps Memorial Health
Center

Sacred Heart Hospital

Richland County Health
Dept.

Missoula Home Health
Agency

Ravalli County Public
Health

St. Joseph Home Health
Care Agency

Flathead City-County Home
Health

Visiting Nurse Association
of the Denver Area, Inc.

Dominican Sisters of the
Sick and Poor

Jefferson County Health
Dept.

Visiting Nurse Association
of Boulder County, Inc.

Larimer County Visiting
Nurse Association

Rehabilitation and Visiting
Nurse Association

Colorado Springs Visiting
Nurse Association

DePaul Hospital Home Care
Service

Community Home Health
Care Agency

Visiting Nurse Service, Inc.

Good Samaritan Hospital
Home Health Care Service

Scottsdale-St. Luke's Home
Health Agency

Coordinated Home Health
Service

Payson Home Health
Agency

Home Health Agency of
Pima County

Yavapai County Home
Health Agency

Sunrise Home Health Care
Program

Nevada Home Health
Services, Inc.

Kaiser Permanent Medical
Care

Visiting Nurse Association
of Los Angeles, Inc.

Hospital Home Health Care
Agency

City of Hope Home Health
Agency

Verdugo Hills Visiting
Nurses Association

National In-Home Health
Services

Visiting Nurses Association
of San Gabriel Valley

Continuity of Care Home
Health

Total Care, Inc.

Visiting Nurse Association
of San Diego County

Allied Home Health Agency

Allied Home Health
Association

Home Care Department

Town & Country Home
Nursing Service

Visiting Nurse Association
of Orange County

Home Health Agency of San
Luis Obispo

Saint Agnes Home Care
Agency

Fresno Community Hospital
and Center—Home Health
Service

Salinas Valley Visiting
Nurse Association

Monterey Peninsula Visiting
Nurse Association, Ltd.

Visiting Nurse Association
of San Francisco, Inc.

Mt. Zion Hospital & Medical
Center

San Francisco Home Health
Service

Vesper Home Care

Home Health and Counsel-
ing Service

Visiting Nurse Association
Serving Alameda County

Visiting Nurse Association
of Santa Cruz County

South Bay Home Health
Agency

Alexian Brothers Hospital
Home Health Care Service

Home Health Service/Visit-
ing Nurse Association of
San Joaquin

Humboldt County Home
Health Agency

Community Home Health
Services

Straub Clinic and Hospital,
Inc.

Southeastern District
Health Dept.

District 7 Health Dept.

Home Health Center/Mercy
Medical Center

Community Home Health,
Inc.

N. Idaho Home Health

Panhandle Health District
#1

The Dallas General Hospital	Spokane Visiting Nurse Association
Clatsop County Home Health Service	St. Luke's Home Health Agency
Yamhill County Home Health Agency	Anchorage Home Health Agency
Portland Visiting Nurse Association	Cabarrus County Home Health Agency
Portland Adventist Home Health Agency	Lincoln County Home Health Agency
Marion County Health Dept.	Cleveland Home Health Agency
Home Health Agency of Salem, OR	Total Care, Inc.
Bay Area Hospital Home Health	Scotland County Home Health Agency
Harney County Home Health Agency	Caldwell County Home Health Agency
Seattle/King County Visiting Nurse Service	Visiting Health Professionals
Community Home Health Care	Good Shepherd Home Health Agency
Visiting Nurse Association of Snohomish County	South Carolina Department of Health
Community Homewell	Sea Island Comprehensive Health Care Corporation
Good Samaritan Hospital and Rehabilitation Center	Floyd Home Health Agency
Hospice of Tacoma	Visiting Nurse Association of Metropolitan Atlanta
Home Health Program of Yakima, WA	Ogeechee Home Health Agency
N.E.W. Health Programs	

Mountain Home Health Agency	Professional Home Health Care
St. Mary's Home Health Agency	Professional Home Health Care of East Tennessee, Inc.
CSRA Home Health Agency, Inc.	Home Health Care
Health Help Services, Inc.	Mid-South Comprehensive Home Health Service
District XV Home Health Agency	Maury Home Health Agency
Chattahoochee Valley Home Health Agency	Delta Medical Center
St. Vincent's Medical Center	North Mississippi Home Health Agency
Florida Home Health Services	Tennessee Valley Health Service
Suncoast Home Health Services	Home Health Service of Mississippi
Complete Care, Inc.	Central Mississippi Home Health Agency
Medi-Health, Inc.	Covington County Hospital
American Home Health Care	Community Home Health Care Association
Visiting Nurse Association of Hillsborough County	Alexander's Home Health Agency
Mid-South Home Health Agency	Whitley County Home Health Agency
Alabama Department of Health	Knox County Home Health Agency
West Alabama Home Health Agency	Frontier Nursing Services, Home Health Agency
Community Health Services, Inc.	

No. 82-991

Office-Supreme Court, U.S.

FILED

JAN 26 1983

ALEXANDER L. STEVAS,
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1982

NATIONAL ASSOCIATION OF HOME HEALTH
AGENCIES, ET AL., PETITIONERS

v.

RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly held that 42 U.S.C. 1395kk(a), which authorizes the Secretary of Health and Human Services, in administering the Medicare Program, to "perform any of his functions directly, or by contract * * * as the Secretary may deem necessary," authorizes the Secretary to contract with private fiscal intermediaries to perform the function of reimbursing providers of services under the Medicare Program.

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THE DISTRICT OF COLUMBIA CIRCUIT*

BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-37a) is reported at 690 F.2d 932. The opinion of the district court (Pet. App. 40a-60a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on September 14, 1982. The petition for a writ of certiorari was filed on December 13, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under Part A of the Medicare Act, 42 U.S.C. (& Supp. V) 1395c-1395i, the Secretary of Health and Human Services is authorized to reimburse health care providers, including home health agencies (HHAs), for the reasonable

cost of providing a variety of inpatient hospital services, post-hospital extended care services, and home health services to Medicare beneficiaries. 42 U.S.C. (& Supp. V) 1395f(a) & (b), 1395x(m), (o) & (u). At the Act's inception in 1965, HHAs, like other qualified providers, had the option of nominating a fiscal intermediary to determine the proper amount of reimbursement and to make those payments, pursuant to a cost-reimbursement contract with the Secretary. 42 U.S.C. (Supp. V) 1395h(a). Alternatively, if the provider elected not to nominate an intermediary, it submitted its claims directly to the Secretary, through the Office of Direct Reimbursement (ODR) of the Health Care Financing Administration (HCFA). Under the Act, the Secretary was empowered to perform any of his functions "directly, or by contract." 42 U.S.C. 1395kk(a).

In 1977, Congress acted to limit a provider's right to select a particular intermediary by giving the Secretary the discretionary authority to assign or reassign providers from the intermediary of the provider's choice to another intermediary. The Secretary was also given the discretion to designate a regional or national intermediary for a class of providers. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95-142, 91 Stat. 1199, codified at 42 U.S.C. (Supp. V) 1395h(e)(1)-(3) and 1395h(f). Finally, in 1980, concerned with the "wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers,"¹ Congress further amended the Medicare program provisions as they pertained to HHAs. In Section 930(o)(4) of the Omnibus Reconciliation Act of 1980, 42 U.S.C. (Supp. V) 1395c, Congress required the Secretary to designate regional intermediaries "to perform

¹H.R. Rep. No. 96-1167, 96th Cong., 2d Sess. 368 (1980).

functions * * * with respect to [free-standing] home health agencies²] * * * in the region," in order to administer the HHA reimbursement process more effectively and efficiently. 42 U.S.C. (Supp. V) 1395h(e)(4).

Following passage of the 1977 amendments to the Medicare Act, the Secretary initiated a proposal to designate intermediaries to serve all freestanding home health agencies on a state-wide basis, in order to lower costs and more effectively protect the HHA reimbursement process against possible fraud or abuse (C.A. App. 46).³ In August 1981, after receiving comments on the proposal from representatives of the HHA community (C.A. App. 51, 57) and after enactment of the 1980 amendments to the Act, the Secretary approved a plan for designating regional intermediaries (C.A. App. 69). Four months later, on December 8, 1981, the Secretary issued an administrative instruction requiring freestanding HHAs to begin submitting their claims to designated state-wide intermediaries for all Medicare reimbursement determinations and payments (Pet. App. 4a). Of the 864 HHAs that were to be reassigned under the instruction, approximately 54% were providers that previously had chosen to deal directly with the Secretary (*id.* at 4a-5a).

2.a. On December 24, 1981, petitioners—two national associations of HHAs, a corporation that owns and operates 48 HHAs, and 37 individual HHAs—filed the instant action in the United States District Court for the District of Columbia seeking to enjoin the implementation of the Secretary's proposed reassignments. The complaint alleged

²"Freestanding" home health agencies are not affiliated with another provider, such as a hospital, skilled nursing facility, or rehabilitation facility.

³"C.A. App." refers to the joint appendix filed in the court of appeals.

that the Secretary's designation of regional intermediaries violated the Medicare Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution.

On March 10, 1982, the district court ruled in petitioners' favor on most of the issues raised (Pet. App. 40a-61a). The court held that it had jurisdiction over all of petitioners' claims under 28 U.S.C. 1331, notwithstanding the prohibition in 42 U.S.C. 405(h)⁴ against the bringing of any action under 28 U.S.C. 1331 to recover on any claim arising under the Medicare Act (Pet. App. 42a-50a). On the merits, the district court held that HHAs have a right under the Medicare Act to deal directly with the Secretary on reimbursement matters. In addition, as to those HHAs that previously had elected to be reimbursed through an intermediary and that the Secretary proposed to reassign to another intermediary, the court prohibited any reassignments from taking effect until the Secretary followed the notice and comment procedures of the Administrative Procedure Act (Pet. App. 57a-61a).

b. The court of appeals affirmed in part and reversed in part (Pet. App. 1a-37a). The court of appeals agreed that the district court had jurisdiction over all of petitioners' claims under 28 U.S.C. 1331 and that this jurisdiction was not expressly barred by 42 U.S.C. 405(h) or implicitly barred by Congress' failure to provide for judicial review of reimbursement reassignment decisions even though it did provide for judicial review with respect to other Medicare determinations (Pet. App. 6a-18a).

On the merits, however, the court of appeals held that the Secretary possessed the authority under the Medicare Act,

⁴42 U.S.C. 405(h) is applicable to Medicare cases by virtue of 42 U.S.C. 1395ii.

42 U.S.C. 1395kk, to contract out the reimbursement function and thereby, in this case, to require freestanding HHAs to submit their Medicare reimbursement claims to designated regional intermediaries for processing and payment (Pet. App. 8a-31a). In reaching this conclusion, the court noted that an interpretation of 42 U.S.C. 1395kk permitting the Secretary to contract out any of his reimbursement functions is consistent with the generally accepted principle that "a government entity empowered to perform a function has the authority to use any reasonable tools and means to carry out that function" (Pet. App. 20a, citing *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819)). The court rejected petitioners' contention that 42 U.S.C. (& Supp. V) 1395g—which provides generally for the Secretary to pay providers of services—grants them an unqualified right to be reimbursed directly by the Secretary, finding instead that that provision "merely requires the Secretary periodically to determine the amount due a provider and to pay that amount at least monthly" (Pet. App. 20a). Accordingly, Section 1395g was held not to limit the Secretary's authority under Section 1395kk to perform this function "directly, or by contract * * *."

The court of appeals found its conclusion that Section 1395kk authorizes the Secretary to contract out his reimbursement responsibilities "bolstered" by the legislative history of the Act (Pet. App. 20a-21a). In contrast, the court found that the portions of the legislative history cited by petitioners pertained not to the contracting authority in Section 1395kk but instead to Section 1395h(d), which in effect provides that a member of an association of providers cannot be bound by that association's choice of a particular intermediary (Pet. App. 23a-25a). These passages from the legislative history, the court concluded, in no way intimate that the *Secretary* cannot make such a choice (*id.* at 24a).

Finally, the court of appeals rejected petitioners' contention that the Secretary's authority to contract out the reimbursement function was barred by a 1966 opinion of an Assistant General Counsel of the Department of Health, Education, and Welfare or by the Secretary's prior practice of permitting direct dealing (Pet. App. 28a-31a):

The Secretary's authority to contract out his reimbursement responsibilities did not dwindle away over time as he chose not to use it. Congress conferred that authority upon the Secretary and only Congress could withdraw it. Neither the Office of General Counsel by its opinions, nor the Secretary by his inaction could diminish that authority in the least.

Id. at 31a. The court also noted that the opinion of the General Counsel's Office did not take into account the legislative history of the 1966 Act that supports the Secretary's authority to contract out the reimbursement function (*id.* at 30a).

Although the court of appeals concluded that the Secretary had the statutory authority to contract out the reimbursement function, it held that the Secretary was required to follow the notice and comment procedures of the APA before assigning HHAs to intermediaries. The court therefore held that the Secretary may not reassign petitioners to intermediaries until he provides adequate notice and an opportunity for comment (Pet. App. 31a-37a).

ARGUMENT

The court of appeals has sustained the Secretary's authority, expressly granted by the Medicare Act itself and confirmed by the legislative history of that Act, to perform the function of reimbursing providers through intermediaries with which he has contracted. This holding is correct, does not conflict with any decision of this Court or any

court of appeals, and presents no issue warranting further review.

1. The court of appeals correctly held that the Medicare Act empowers the Secretary to contract out the function of reimbursing providers under Part A of the Act and thereby to require freestanding HHAs to submit their reimbursement claims to fiscal intermediaries rather than directly to the Secretary. The Secretary is explicitly authorized by the Medicare Act to "perform any of his functions * * * directly, or by contract providing for payment in advance or by way of reimbursement * * * as the Secretary may deem necessary." 42 U.S.C. 1395kk(a). This broad language, on its face, surely encompasses the contracting out of the Secretary's reimbursement responsibilities, the most routine of his duties under the Act and a function that private contractors, such as insurance carriers, are especially well suited to perform. As this Court often has recognized, language as plain and direct as this "must ordinarily be regarded as conclusive" in the absence of a "clearly expressed legislative intention to the contrary." *Bread Political Action Committee v. Federal Election Commission*, No. 80-1481 (Mar. 8, 1982), slip op. 3, citing *Consumer Product Safety Commission v. GTE Sylvania*, 447 U.S. 102, 108 (1980).

Here, far from expressing a contrary intention, the legislative history makes clear that Congress specifically intended that the Secretary could contract out the reimbursement function pursuant to 42 U.S.C. 1395kk even where the provider had declined to nominate a particular intermediary and thus would otherwise be reimbursed directly by the Secretary. The Senate Finance Committee's report on the Act states:

Under the [proposed bill], nominated organizations having experience with cost reimbursement could determine the amount of payments and make such

payments whether under part A or part B. *In the absence of a suitable nominated organization, the Secretary could contract out all or part of this service or handle the function directly.*

S. Rep. No. 404, 89th Cong., 1st Sess. 53 (1965) (emphasis added). See also H.R. Rep. No. 213, 89th Cong., 1st Sess. 174 (1965).⁵

2. Petitioners contend (Pet. 7-8) that the court of appeals' holding that the Secretary may contract out any of his functions under the Medicare Act could lead to a "drastic change" in the way in which the Medicare program is administered. Petitioners even suggest that the decision below would permit the Secretary to contract to private parties his statutory duties of serving as a member of the Board of Trustees of the Part A and Part B Trust Funds (see 42 U.S.C. (& Supp. V) 1395i(b) and 1395t(b)), establishing the amount of premiums Part B beneficiaries must pay (42 U.S.C. (& Supp. V) 1395r), and appointing the members of the Provider Reimbursement Review Board (42 U.S.C. 1395oo(a)).

⁵Petitioners' reliance on other portions of the legislative history of the Medicare Act and amendment thereto (Pet. 10 & n.11) is misplaced. As the court of appeals noted (Pet. App. 22a-28a), all but one of the passages invoked by petitioners pertain to 42 U.S.C. 1395h(d), which merely states that a provider is not bound by the selection of a particular intermediary by an association to which the provider belongs. The fact that a provider is not bound by its association's choice of an intermediary does not suggest that a provider is not bound by the Secretary's decision to contract out part of the reimbursement function.

The remaining passage of the legislative history cited by petitioners (Pet. 10) again pertains not to Section 1395kk but instead to a 1980 amendment requiring the Secretary to designate regional intermediaries for freestanding HHAs. The passage quoted indicates only that the Secretary would remain free to deal directly with freestanding HHAs if he elected to do so (see Pet. App. 25a-26a, 28a).

There is no need to speculate about the validity of these far-fetched examples. All that this case involves—and all that the court of appeals' opinion addresses—is the Secretary's authority to enter into contracts for the determination and payment of reimbursement claims by intermediaries rather than by the Secretary. The Act on its face contemplates that the reimbursement functions under Part A and Part B may be performed by private insurance carriers and similar entities pursuant to contract with the Secretary, and the reimbursement function in fact typically is performed by such entities. See 42 U.S.C. (& Supp. V) 1395h and 1395u; *Schweiker v. McClure*, 456 U.S. 188 (1982); *United States v. Erika, Inc.*, 456 U.S. 201 (1982). The court of appeals' sustaining of the Secretary's authority to enter into contracts with intermediaries for the reimbursement of petitioners therefore scarcely represents a "drastic change" in the way the Medicare program is administered.⁶

⁶Petitioners assert (Pet. 8) that the decision below conflicts with *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 282, 293 (8th Cir.), cert. denied, 429 U.S. 977 (1976), where the Eighth Circuit held that the Secretary must retain sufficient power to review intermediary determinations in reimbursement disputes to assure compliance with Medicare statutes and regulations. Petitioners contend that under the rationale of the decision below, the Secretary could contract out the very function that the Eighth Circuit held in *St. Louis University* must be retained. This contention is without merit.

This case involves only the authority of the Secretary to perform the reimbursement function by contract under Section 1395kk, not to contract away his final authority for construing the Act. Section 1395kk was not at issue in *St. Louis University*. Moreover, in that case, the initial reimbursement determinations were made by intermediaries. The Eighth Circuit's decision involved only the degree of control the Secretary must retain over the operations of intermediaries, an issue not raised here. In any event, the Eighth Circuit's concerns about the use of intermediaries have been dispelled by this Court's decision in *Schweiker v. McClure*, *supra*, sustaining the authority of Congress to vest final decision-making authority in reimbursement disputes in private insurance carriers serving as intermediaries.

3. Nor does the Secretary's previous practice of reimbursing directly those providers that had not nominated an intermediary foreclose the Secretary from deciding in light of current circumstances that this function now should be performed by contract in the case of certain providers, such as freestanding HHAs. As the court of appeals observed, quoting this Court's decision in *United States v. Morton Salt Co.*, 338 U.S. 632, 647-648 (1950), powers granted by Congress "are not lost by being allowed to lie dormant" (Pet. App. 30a).

Petitioners contend (Pet. 9) that over a period of 15 years there has been a consistent administrative interpretation of the statute as furnishing providers a right to elect to be reimbursed directly by the Secretary. The only document cited by petitioners that focused on this question, however, is a 1966 opinion of an Assistant General Counsel of HEW. As the court of appeals noted (Pet. App. 30a), subsequent opinions issued by the same Office have taken a contrary view. Moreover, the 1966 opinion itself did not take into account the legislative history of the Act, quoted above, that specifically states that the Secretary may contract out all or part of the reimbursement function if a provider does not nominate a suitable organization to perform that function. See pages 7-8, *supra*. The court of appeals correctly observed (Pet. App. 29a n.87) that the regulations cited by petitioners (Pet. 9)⁷ reflect only the past practice pursuant to 42 U.S.C. 1395h, under which a provider had been permitted to elect to deal either with an intermediary or with the Secretary. The regulations do not address the distinct authority of the Secretary under Section 1395kk to perform the reimbursement function "directly, or by contract * * *."⁸

⁷42 C.F.R. 421.103 and 421.104(b)(2).

⁸Petitioners' concerns (Pet. 4-5) regarding the degree to which any incremental costs of dealing with intermediaries rather than directly with the Secretary will be reimbursed by Medicare are misplaced in the

Finally, contrary to petitioners' contention (Pet. 14-15), the decision below is consistent with the principles of *SEC v. Chenery Corp.*, 318 U.S. 80 (1943). In *Chenery*, this Court held (*id.* at 88) that where an agency order is predicated on a "determination of policy or judgment which the agency alone is authorized to make and which it has not made," a reviewing court may not sustain the order on other, alternative grounds. This rule, designed to prevent appellate courts from "intrud[ing] upon the domain which Congress has exclusively entrusted to an administrative agency" (*ibid.*), is inapplicable to the instant case. Here, the Secretary plainly had made the policy choice to contract out the reimbursement function. The issue addressed by the court of appeals was not the merits of the Secretary's reassignment decision, but whether he had the authority, under the Medicare Act, to make such reassignments. In these circumstances, the court of appeals' reliance on the contracting authority in 42 U.S.C. 1395kk, a Section that was not identified in the Secretary's administrative instruction, was not improper under *Chenery*, since it did not cause the court to make policy judgments entrusted to the Secretary alone. Accordingly, the court of appeals' ruling does not conflict with this Court's prior decisions.⁹

instant suit. A judicial challenge to a reimbursement decision may be brought only pursuant to 42 U.S.C. (& Supp. V) 1395oo, and then only after a claim for reimbursement has been presented to and denied by the intermediary and the Provider Reimbursement Review Board.

⁹The court of appeals held (Pet. App. 6a-18a) that the district court had jurisdiction to consider petitioners' claims under 28 U.S.C. 1331, notwithstanding the bar in 42 U.S.C. 405(h) (as incorporated into the Medicare Act by 42 U.S.C. 1395ii) to the bringing of any action under 28 U.S.C. 1331 to recover on a claim arising under the Medicare Act. See *Weinberger v. Salfi*, 422 U.S. 749, 756-762 (1975); cf. *United States v. Erika, Inc.*, No. 81-1594 (Apr. 20, 1982). The correctness of this jurisdictional holding would be presented as a threshold matter if the Court were to grant certiorari in this case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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JANUARY 1983